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Footnotes, bibliographies and legends should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodicals with volume, page,—and year.

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

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VOLUME 1 *February, 1952* NUMBER 2

COMMENTS

GEORGE H. YEAGER, M.D.

Editor and Secretary

"Unimportant of course, I meant," the King hastily said, and went on to himself in an undertone, "important, unimportant, important" as if he were trying which word sounded best.—Alice in Wonderland, Lewis Carroll.

The purposes of this Faculty shall be to federate and bring into one compact organization the medical profession of the State of Maryland; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to foster friendly intercourse among physicians; and to enlighten and direct public opinion so that the profession shall become more useful in the prevention and cure of disease; in prolonging and adding comfort to life, and in promoting a satisfactory distribution of medical care to the citizens of Maryland.

Thus, in Article II of the Constitution and By-Laws of the Medical and Chirurgical Faculty of the State of Maryland the purposes of the Society are defined. Do you help with its purpose? Do you participate in its functions? This organization has been a potent factor in the professional and civic life of Maryland. It can become much more effective if each member will demonstrate at least an active interest in his component society. Vigorous component societies will mean a thriving State Society with expanding interests.

Establishment of the Maryland State Medical Journal has resulted in both praise and criticism. Valuable suggestions have been contained in some of the criticisms. In addition to the other purposes of the Journal, let us use it as a "sounding board" not for the "staff" nor the officers, but for the individual membership. Long has there been need of such! In addition to containing news, and scientific information, let it serve as a medium for the exchange of ideas. Utilize the Journal to further enhance the purposes of this Society. Thereby, it can serve as a medium of physical access and overcome some of the previous geographical limitations of this Society.

FREDERICK COUNTY ACHIEVES[1]

Under Frederick County Medical Society News the following modest announcement appears: "A unique organization has sprung up in Frederick County known as Hospital Aid, Inc. It has been established and incorporated by civic minded professional, industrial, agricultural and commercial individuals. The aim of Hospital Aid, Inc., is to help directly those confronted with illness or accident which necessitates hospitalization when insufficient funds are available to meet unexpected hospital bills. Hospital Aid, Inc., after proper investigation of requests for assistance, will pay the hospital bill. The loan can be repaid without interest, at a rate convenient for the borrower, as little as a dollar a week." Additional details may be noted in the original announcement.

Such an organization reveals a remarkable concept of *civic pride* and *local responsibility*. Expansion, and integration of this idea to other communities on a nationwide scale, plus existent and contemplated prepayment insurance plans should further weaken the arguments of the "Social Planners" for Nationalization of the Medical Profession.

[1] The development of this movement will be brought to the attention of the American Medical Association.

Reports

COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

BEVERLEY C. COMPTON, M.D., *Chairman*

The Annual Meeting of the Medical and Chirurgical Faculty will again be held in our building on Monday, Tuesday and Wednesday, April 28, 29 and 30, 1952.

Monday will be devoted to business sessions and Tuesday, April 29, and Wednesday, April 30, will be primarily scientific sessions with some business meetings interspersed.

On Tuesday, all features should be of interest to the Component Medical Societies. From 9:00 A.M. to 10:00 A.M., movies will be shown which have been produced in our own local institutions. Following this, from 10:00 A.M. to 11:00 A.M., there will be a Clinical Pathological Conference by the group from the University of Maryland School of Medicine. This will be followed with talks entitled, "You and Your A. M. A.," by speakers furnished by the American Medical Association. The office of the Medical and Chirurgical Faculty has been besieged with questions regarding the activities of the American Medical Association. This part of the program is an attempt to answer these queries. Following the presentation by the American Medical Association delegates, there will be a one-half hour period devoted to questions and answers.

On Tuesday afternoon, from 2:00 P.M. to 4:00 P.M., the session will consist of a Panel Discussion on the "Contraindications to ACTH and Cortisone," with Dr. Warde B. Allan, moderator, and Dr. A. McGehee Harvey and Dr. John C. Krantz, Jr., speakers.

On Tuesday evening we have the Presidential address by Dr. Alan M. Chesney, followed by Dr. C. P. Rhoads, Director, Memorial Center for Cancer and Allied Diseases and Professor of Pathology, Cornell University Medical College, who will give a talk on "Recent Developments in Cancer Research."

Wednesday, April 30th, we will again have our locally produced movies from 9:00 A.M. to 10:00 A.M. From 10:00 A.M. to 11:00 A.M., a Clinical Pathological Conference will be presented by The Johns Hopkins University School of Medicine group. From 11:00 A.M. to 11:30 A.M., Sir Allen Daley, Medical Officer of Health of London County Council, will discuss "The Relative Position of the Specialist, the General Practitioner and the Public Health Officer in Britain." From 11:30 A.M. to 12:30 P.M., we are fortunate in securing Dr. Osler A. Abbott, of the Emory University School of Medicine, who will talk on "The Recent Advances in Surgery of the Autonomic Nervous System."

The Wednesday afternoon session, from 2:00 P.M. to 4:00 P.M., will be taken by the Chest group, with a Panel Discussion.

The speaker for Wednesday evening, at this writing, has not been secured. Preceding the Wednesday evening address, a delectable buffet supper will be served.

The Committee on Scientific Work and Arrangements urges the members to set aside this time for the purpose of attending the Annual Meeting of their State Medical Society. Attendance in the past by our members, as compared to other state societies, has always been very poor. The above program should stimulate better attendance.

"The Council of the Medical and Chirurgical Faculty is in full support of the Board of Medical Examiners in their action in taking the licenses away from physicians convicted in Court of income tax evasion, and further desires that this support by the Council be publicized in the Maryland State Medical Journal."

COMMITTEE FOR THE STUDY OF CERTAIN PHASES OF MEDICAL ECONOMICS*

WALDO B. MOYERS, M.D., *Chairman*

PRIVATE OR GOVERNMENT CONTROL OF THE PRACTICE OF MEDICINE

Which do you want? Are you willing to work and fight for private control of the medical profession? If so, it is time to start or we will be behind the proverbial "eight ball" before we realize it. The economic side of medicine is basic in its control. Once a doctor is not able to make a decent living for himself and family he will start looking for some other method. This is our vulnerable spot and we are doing very little about it.

Let's take a look at the picture. A student finishing high school, if he wishes to become a doctor, enters a period of training from eight to thirteen years. At the end of this period when he starts to practice he has an investment of at least thirty-five thousand dollars (see report). He now must build up a practice and is eight to thirteen years behind the individual who started in business after high school. His investment is considered a capital asset but there is no way to deduct this as other business men do. This has no capital value to anyone but the doctor and is completely wiped out at death or disability. Still the doctor pays income tax the same as the man who started earning at 18. The doctor also has to keep up a higher standard of living, and to contribute freely to all community projects, and is always charged top price for any work done.

The following report by Frank G. Dickinson, Ph. D., Director of the Bureau of Medical Economics Research A.M.A., gives some very interesting figures. This report was published in April, 1950.

Tuition, books, fees, etc. (excluding living expenses)	$3,500.00
Amount lost—9 Yrs. training	26,500.00
Total	$30,000.00
Interest	5,000.00
Total	$35,000.00

Cost of carrying this load

1. Interest 4%	$1,400.00
2. Cost of annuity of this amount per yr.	$800.00
3. Cost of running an office	$2,200.00
4. Earnings necessary to meet these expenses	$50,000.00

Specialty training would probably add about $10,000.00 to the cost.

When a doctor wishes to improve himself and practice better medicine he takes postgraduate work. During this period he loses his income, his expenses go on, and he has to pay all expenses for his training. The Bureau of Internal Revenue has ruled that post graduate education is a personal expense and not deductible. This makes it very difficult for a doctor to try to improve his medical ability because of the economic problem.

With the above factors in mind how can a young doctor prepare for the future of his family and himself? His so called capital assets, produce income only while he can work, and have no value to his family after he dies or is disabled. The older men, who had good incomes before the income tax became so high, are in much better condition economically but what of their children and grandchildren who wish to study medicine? The inheritance tax will soon bring all to a common level and the income taxes are increasing every year.

Your Committee for the Study of Certain Phases of Medical Economics begs you to think about this problem and help by setting up a committee in your society as we have requested through your president and secretary.

We advocate three changes in the present laws and we feel that this movement will have to be started at

* *Editor's Note:* The appointment of this Committee was authorized by the House of Delegates in April 1951, and its first report was presented at the Semiannual Meeting in September 1951. Dr. Moyers and his Committee have requested the Component Medical Societies to appoint local committees to study this problem, make suggestions and work in conjunction with the Faculty Committee, which is composed of the following members: Wolcott L. Etienne, M.D.; Houston Everett, M.D.; Thomas K. Galvin, M.D.; Frank J. Otenasek, M.D., and Waldo B. Moyers, M.D., Chairman.

a State level. If enough States will do this it will be much easier to get national legislation. If something is not done to alleviate this situation the only answer is government subsidies and eventual control.

The three changes are as follows:

1. Legislation to allow deduction or amortization of the capital assets involved in all technical and professional training over an appropriate period of time.
2. Deduction of postgraduate education in the same manner.
3. Setting up of retirement funds during active practice, taxable only on payment from fund to the doctor.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

This Committee, sponsored by the Maryland Division of the American Cancer Society and authorized on April 23, 1951, by the House of Delegates of the Medical and Chirurgical Faculty, has been in operation since September. The purpose of the Committee is the study of delay periods in the treatment of pelvic cancer and to attempt to reduce these delay periods. The Committee is established along the lines of similar Committees in Philadelphia and Boston, where successful studies have been conducted over the past several years.

The following Baltimore hospitals are cooperating in the study: Baltimore City Hospitals, Bon Secours Hospital, Church Home Hospital, Johns Hopkins Hospital, Lutheran Hospital, Sinai Hospital, University Hospital and Women's Hospital.

All ward and clinic patients with pelvic cancer who are being treated in these hospitals may be interviewed by our secretary. Private patients are interviewed at the request of the visiting doctor. From the data thus collected, cases are selected for discussion at the monthly meetings of the Committee. All doctors concerned with the cases are invited to attend the meetings. It is the hope of the Committee that by open and frank discussions of the problems in diagnosis and treatment of pelvic cancer, that the delay period which often occurs before adequate therapy is initiated, may be reduced.

Abstracts of case histories and discussions held at the meetings will appear in future issues of this Journal.

Meetings are held the third Thursday of each month from 5–6 P.M. in the Medical and Chirurgical Faculty Building. All physicians are cordially invited to attend these meetings.

SYMPOSIUM ON MEDICAL ASPECTS RELATING TO EUTHANASIA

Arranged under the auspices of the Symposia Subcommittee of the Medicolegal Committee of the Baltimore City Bar Association and the Medical and Chirurgical Faculty.

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, March 28, 1952, 8:00 p.m.

PANEL DISCUSSION

MR. JOHN S. STANLEY, *Moderator*
President, Maryland State Bar Association

1. Historical Development of Euthanasia. George Boas, Ph.D., LL.D., Professor of the History of Philosophy, The Johns Hopkins University.
2. Legal Aspects Relating to Euthanasia. Charles E. Orth, Esq., Formerly Assistant State's Attorney of Baltimore City.
3. Medical Aspects Relating to Euthanasia. Louis Krause, M.D., Professor of Clinical Medicine, University of Maryland School of Medicine.

Questions from the floor.

Scientific Papers

PANEL DISCUSSION: PEPTIC ULCER[1]

The Baltimore City Medical Society held a Panel Discussion on Peptic Ulcer, on Friday, November 16, 1951, at 8:30 P.M., at the Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore 1, Maryland, with Dr. Louis A. M. Krause, President, presiding and Dr. Harvey B. Stone as Moderator.

HARVEY B. STONE, M.D., *Moderator*

Will the members of the Panel come up front and take their seats? I think Dr. Fort and his Program Committee have been eminently successful at least in advertising this occasion as the attendance is better than I have seen at a Society meeting in some time. In the choice of subject, it seems to me, they have been very wise because peptic ulcer is a condition certainly of widespread occurrence and apparently increasing frequency. I think if one can believe the things read in the newspapers and elsewhere, peptic ulcer has become a sort of class distinction. The Hollywood Producers and business executives seem to feel they are not really in the first rank unless they can lay claim to possession of peptic ulcer, and I have had the feeling frequently in taking the history of patients that maybe the diagnosis of ulcer is more frequent than ulcers. It is not at all uncommon for a patient to tell me "five years ago I had a duodenum ulcer, I was treated for it for about three weeks and got over it and haven't had any trouble since." Now that is entirely possible but it has provoked a certain amount of skepticism on my part as to the ease with which the diagnosis of peptic ulcer seems to be made even by the general public; apparently if somebody has some digestive disturbance and a little bit of pain it is assumed as a matter of course that he has peptic ulcer.

I might say there has been some criticism as to the title of the subject we have tonight. Certain purists claim that the term "peptic ulcer" in itself is a misnomer, that there is no evidence at all to show that pepsin *per se* has much to do with the development of these ulcers, and that another name, a more exact name, should be adopted. However, peptic ulcer is a term of such wide acceptance and established usage, it is foolish to quibble about a word of that sort.

Just a remark about the operation of the program tonight. These gentlemen sitting beside me constitute the panel who will present various aspects of this topic from the point of view of the specialty or general field in which they themselves are active. At the end of these talks, the meeting will be thrown open to general inquiry;—not general discussion but general inquiry. We cannot, unfortunately I think, manage the meeting if people just get up and ask questions. Questions will have to be submitted in writing and it probably will happen that a good many people will submit the same questions so there will be a good deal of overlapping. I might say we already have a number of questions, sent in prior to the meeting, and there are at each seat pieces of paper on which anyone is invited and urged to submit a written question. At the end of the

[1] Presented before the Baltimore City Medical Society, Friday, November 16, 1951.

formal presentation tellers will collect those papers and we will try to organize them and submit them to one or more of the speakers on the panel, directing the question to the man or men in whose bailiwick the question most naturally fits.

Now you know all these people, but I should like to introduce them in the order in which they will speak and identify them as to the particular field which they will cover. Dr. Sherman M. Mellinkoff will talk from the standpoint of the Internist and General Medicine; Dr. John Tilden Howard will speak from the standpoint of the Gastroenterologist; Dr. Jacob E. Finesinger represents Psychiatry in its interest in Peptic Ulcer; Dr. David M. Gould, pinch-hitting for Dr. Russell Morgan will take care of the Roentgenological aspect of the topic, and Dr. C. Reid Edwards will speak for the Surgeon's standpoint of it. Now, Dr. Mellinkoff can you lead off?

INTERNAL MEDICINE

SHERMAN M. MELLINKOFF, M.D.

I don't know whether Emily Post was the first one to say this but it is certainly true: One excuse is always preferable to two; and much more convincing. If that be true we are in for a bad evening, because it would appear that we all know so little about peptic ulcer that we have had to get six men to tell about it. I think however, it is well to begin by admitting that after all the years of research in this field, we do not know exactly why some people get peptic ulcers and others do not. I think about all we can say in that regard is to list a few things we do know, admitting they are not the whole story.

The first thing we know about the pathogenesis of peptic ulcer, I think, is that it is practically impossible, or at least by definition impossible, to have a peptic ulcer without free hydrochloric acid. While there are rare instances reported in the literature of benign ulcers in the stomach and even rarer ones in the duodenum in which there was histamine achlorhydria, it certainly is true that in several thousand cases of true histamine achlorhydria, such as patients with pernicious anemia, no true ulcer has been found in autopsy series.

I think the second thing that has been shown in human beings as well as in Dr. Wangensteen's experimental dogs, in Minnesota, is that peptic ulcer is found more commonly in animals or in men who have been subjected to emotional or physical trauma. Dr. Finesinger later will discuss, I presume, the particular types of emotional trauma that lead to peptic ulcer formation. It is interesting to note that varying types of trauma will lead to peptic ulcer in dogs. This seems to tie in with the fact that severely burned patients or patients who have been through severe accident are liable to develop acute ulceration.

The reason for this relationship is not known but I think that the recent findings in regard to peptic ulcer with ACTH may have some bearing on this subject. At least it is refreshing to find that ACTH will not cure peptic ulcer, and even that ACTH will make it worse, and it is interesting that ACTH is produced in response, as we all know, to any number of different non specific stresses such as burns, fractures and emotional stimuli. Why ACTH behaves that way pushes the problem one step farther but not much nearer solution. We might mention that it has been shown that ACTH will increase the output of hydrochloric acid and pepsin in a normal stomach; whether that is the whole story is a very debatable point.

Finally, why it is that certain kinds of brain lesions such as ordinary strokes and certain kind

of brain tumors will predispose to peptic ulcer formation I cannot say and perhaps Dr. Finesinger could shed some light on that subject.

As to the symptoms of peptic ulcer, I certainly would agree with Dr. Stone that the diagnosis is often made when the disease is not present, and would like to add subject to his approval, on the other side of the coin, that the diagnosis is often not made when the ulcer is present.

Recently, I went through the charts of thirty-nine patients with duodenal ulcer we had seen in the G.I. clinic at Johns Hopkins in the last two months. In over half of these the patient had suffered dyspepsia of various kinds and had been treated and mistreated with a variety of medications between two and twenty-five years before the diagnosis of peptic ulcer was made and before proper therapy was instituted. I think this is an important thing to remember, because peptic ulcer is so much easier to treat, than is "indigestion" about which the doctor has no conviction. If he can tell the patient and tell himself that he knows this patient has a peptic ulcer he is much more apt to give intensive and adequate treatment, than if the patient remains somewhat of an enigma probably representative of "functional indigestion."

In these thirty-nine patients the same thing has been found with regard to symptomatology as has been pointed out by Bockus and many others in going over thousands of cases of peptic ulcer. That is, that almost any kind of indigestion may be produced by an ulcer and in fact ulcers may bleed, perforate and stenose without prior symptoms. However, two characteristics, if anything is characteristic about this group are: (1) The cyclic nature of the disease, by that I mean the fact that those who had symptoms for a long time tended to have bad periods when pain or nausea, or whatever the discomfort, was present almost constantly, and other periods when they felt perfectly well for long periods and had no symptoms whatsoever. (2) The second thing that was characteristic about the symptoms of the patients in this group, was food relief. There was nothing on physical examination to indicate uncomplicated peptic ulcer except perhaps an appraisal of the patient's psychiatric and emotional background and that will be discussed by Dr. Finesinger. The only sure way I know of to make the diagnosis of peptic ulcer, objectively, short of the occurrence of some catastrophe such as hemorrhage, is by x-ray, and Dr. Gould I presume will discuss the x-ray diagnosis of ulcer.

I would like to go on record with reference to gastric analysis, and perhaps start a controversy by saying I think gastric analysis is highly overrated. I cannot attach much importance to it, except that it may demonstrate achlorhydria. Degrees of hypochlorhydria, or hyperchlorhydria don't help me, I would be interested to hear what the others have to say about it, particularly Dr. Howard because there is so much overlapping between the amount of acid the normal person will secrete and the amount secreted by a patient with an ulcer. This is further complicated by the fact that whereas the mean hydrochloric output in duodenal ulcer patients is higher than normal, the mean hydrochloric acid in gastric ulcer patients is not higher than normal and in many series is even lower than normal.

With reference to treatment of peptic ulcer Dr. Howard is going to discuss its pharmacological aspects, Banthine, atropine and diet, etc. I would like to say; that it is frequently less important what the patient is eating than what is eating the patient. At least we have the best results, I think, in our clinic with patients who come in whenever they are upset, not necessarily whenever their stomachs are upset. It seems to me that is the best way; careful watching of the patient in those periods is the best way to avoid complications of ulcer such as hemorrhage, perforation, stenosis and intractability, which I presume Dr. Edwards will discuss.

Finally, I would like to raise one question for other members of the panel to shed some light upon and perhaps for all of us tonight to think about, that is, the problem of gastric ulcer in

carcinoma. I think this is one of the most highly controversial subjects in the whole peptic ulcer problem. As everyone knows, it is impossible to tell a benign ulcer of the stomach from a malignant ulcer by the symptoms, by signs, or x-ray except in a minority of circumstances. Because of this, people at one extreme of this argument, such as Dr. Ravdin of the University of Pennsylvania have suggested that as soon as the diagnosis of gastric ulcer is made, the patient should undergo exploratory laparotomy and at least subtotal gastric resection, depending upon the findings. At the other end of the pole are those who say gastric ulcers, if they are on the lesser curvature and if there is free hydrochloric acid present, and if there is no obvious evidence of malignancy, are statistically much more likely to be benign than malignant. Therefore, and particularly in consideration of the low cure rate from surgery in gastric carcinoma, these patients should be given a thorough medical treatment and operated upon only if that fails. My own view about this is perhaps closer to Dr. Ravdin's than the other end, but I would be very happy to hear the other side of this controversial subject.

GASTROENTEROLOGY

JOHN TILDEN HOWARD, M.D.

I want to talk a few minutes about the treatment of ulcer. But, before I begin that I will give my opinion on a few of the questions which Dr. Mellinkoff raised. I *do* think that the determination of gastric acidity is of some value. Of course, in gastric ulcer the acid may be perfectly normal and usually is within normal limits; a determination of gastric acidity in these cases is of little value unless achlorhydria is found. On the other hand, in cases of duodenal ulcer, I am sure that most, though not all, have hyperacidity and hypersecretion. In working rapidly, as we have to do in these days when one doesn't have time for fractional gastric analyses, a determination of the volume and acidity of the fasting stomach juice is often a diagnostic aid but I don't believe that it makes the diagnosis.

Dr. Mellinkoff brought up the question of ulcer and carcinoma and how they should be treated. I think that about five per cent of gastric ulcers become or are malignant and look the same as benign ulcers on the roentgen films. I have just heard Dr. Ochsner say in the past few days that he believes every gastric ulcer should be operated on and that he supports Dr. Ravdin entirely. He says, "How will we ever improve our mortality rate from gastric cancer unless we operate on suspicion?" And he goes so far as to say that everybody who has anorexia and who is beyond the age of forty-five should be explored surgically, even though there is no demonstrable lesion. That, I think is a bit far-fetched, but he says he has done that in the past two years in three or four cases and he has found a cancer every time. He didn't mention the mistakes he made, if he made any. My own feeling is that conservative measures should be given a trial, even though the surgeons are getting so good they can look in and resect a stomach on suspicion and get away with it. I'm in favor of conservative management for three weeks at least of gastric lesions that are roentengenologically and gastroscopically and historically benign and when free acid is present. It seems to me that one will make an awful lot of mistakes and take out too many stomachs which can be salvaged with medical treatment if he operates on suspicion or requires no more than the presence of gastric ulceration to send his patient to the operating room. I shall go a little further

than that and say, we used to hear that all prepyloric lesions were malignant. I have seen many lesions around the pylorus which were benign and, contrary to the old idea, ulceration on the greater curvature near the pylorus may be benign. They have often disappeared with a little medical treatment and they have not returned. Have I missed curing some cancers by continuing medical treatment too long? Yes, I've made some mistakes but I think my successes have far outnumbered the mistakes in diagnosis.

Now we all agree that in the treatment of peptic ulcer we want to relieve the symptoms, to heal the crater, and to prevent recurrences. Also I think we will agree that the natural cycle of the ulcer is in our favor. If we don't do anything of consequence, the patient is quite likely to get better. Almost always, when the patient comes to us, he says, "Yes, a couple of years ago I had an attack like this," or "I've had three of four attacks and they passed over." We do not see the patient when the ulcer begins. I sometimes wish we had some way of looking into the duodena of persons with no more than dyspepsia (I suppose we will have that one day) to find out if there is ulceration. I'd like to diagnose peptic ulceration before the lesion is deep enough to produce a defect on the x-ray. That would be the ideal time to institute treatment. But when an ulcer is found, I think we all feel that the pepsin-acid mechanism should be put out of commission and that can best be done by keeping the acid low, by neutralizing what acid is secreted. To do that, the Sippy regimen was started and, when I came to Baltimore twenty-five years ago, I thought that anybody who wasn't treated in the Sippy manner, that is, with feedings of milk and cream every hour and with an alkali midway between each feeding, was being treated terribly. He wasn't getting the very best. But it wasn't long before I learned that the patients who were treated on a less strict regimen did just about as well as a patient given a very rigid diet.

For the treatment of the usual peptic ulcer we don't put the patient to bed; we give him three soft meals a day with milk and cream or chocolate milk or buttermilk or some palatable protein between meals and at bedtime. Then he is given the popular alkali of the moment. Just now the fashionable alkali seems to be aluminum hydroxide. I think that it is a good medicine but little doses of it don't have much effect. One should give larger doses than I used to prescribe; give a tablespoonful at a time, and not an hour after meals or half an hour after meals, but directly after meals. It's a nuisance to have to stop during a busy day to take a dose of medicine and I think that aluminum hydroxide may well be taken directly after meals. It should also be given at bedtime with the bedtime feeding.

When patients come from a distance they usually arrive with more or less hope and they expect to be helped at once, though they may not say so. For such patients who have peptic ulceration, rest in bed, atropine or Banthine, and calcium carbonate may work a kind of miracle. Calcium carbonate is a very rapidly acting alkali. If these patients have been taking magnesium triscillicate or something of that sort at home and if you give them about 4 grams of calcium carbonate at bedtime, they may say the next morning, "I had a good night, the best in a long time." And they are off to a good start with you—or you with them. Ordinarily, because of its constipating effect, I do not prescribe calcium carbonate; I give Alugel or Gelusil or some preparation of aluminum hydroxide that has a magnesium phosphate in it.

If the rather broad soft meat-free diet doesn't bring relief of symptoms quite promptly, I think one has to go back to the Sippy regimen, put the patient to bed, and give him larger doses of alkali. We always interdict tobacco, coffee and alcohol. I'm certain that coffee stimulates gastric acidity and I'm sure that most patients will take Kaffee Hag and Sanka without much complaint, if they will not substitute milk for coffee. To get users of tobacco to discontinue its use is not easy. But, if one talks to his patients plainly, he can get a very large percentage of them to cut down

on the consumption of tobacco if they don't stop it entirely. I always try to persuade patients with peptic ulceration to leave tobacco alone.

The barbiturates are very helpful to me in managing tense patients with ulcers. Recently in a New Orleans panel discussion on the treatment of ulcer a question was directed to the psychiatrist on the panel; the query was, "Are you afraid that you will get your patients addicted to barbiturates?" The psychiatrist replied, "Yes, that is a danger and it would be very bad." Though the question wasn't directed to me, I couldn't refrain from calling out, "I'd rather have my patient addicted to barbiturates, such as a little phenobarbital, than to tobacco if he had an ulcer."

Of the new anti-spasmodics, which are based primarily on good old atropine, I suppose that Banthine is the one that has been most advertised by the *Reader's Digest*, *Time Magazine*, and the news gathering services. The patient often comes to me with the idea that he should have Banthine prescribed and he may ask for it. Now Banthine does relieve pain, of that I am sure. But it does not in the doses that we can prescribe orally, say 100 mgm., affect the amount of gastric secretions in the least. In about twenty-five per cent of the patients who take therapeutic doses of atropine the secretion is diminished by the drug, so to diminish the amount of gastric juice in a patient with peptic ulceration atropine is of some use, but experience has taught me that Banthine is a better "reliever" of the pain of ulcer. Perhaps we give it in larger doses than we prescribe atropine. I am sure Banthine eases pain because of its relaxing effect on gastric muscles; it relieves spasm. The modern Syntropan and Trasentine haven't very much effect on gastric secretion though they do relieve muscle spasm. Tetraethyl-ammonium chloride isn't used clinically as a blocking agent because it lowers blood pressure so very much and makes the patient feel unpleasantly weak. However, it will temporarily lessen gastric secretion.

Researchers are looking for a drug that can be given the patient orally or hypodermically at bedtime and which will keep his secretion of gastric acid minimal during the night. They will, I think, find such a medicine before long. If 0.3 mgm. per kilo of Banthine is given *intramuscularly* at bedtime, it will have a favorable effect on the acid secretion. My patients just don't like to take a hypodermic at bedtime for weeks and weeks and, as I said, Banthine by the oral route does not work on the secretion. There is coming on the market soon a new drug with the trade name Prantal which may be effective. I haven't used Prantal but I hear that it is a better drug than those that we have had. And another unnamed drug (called UO-385) is being tried for the lessening of spasm and of gastric secretion. It is said to be very efficient in lowering gastric acids and secretion when taken orally. The point is that the chemists are at work on drugs to lessen gastric secretion and that is what we want.

Enterogastrone you have heard about and it has almost been forgotten; it takes so much of it to produce an effect on gastric acidity. A psychic stimulus will raise the gastric acid promptly in spite of enterogastrone. You all know Kutrol (uragastrone). It costs fifty cents a capsule and it has been disappointing; it can't be depended on. It has been advised for the medical treatment of "intractable" peptic ulceration. In the difficult cases it has never been of use to me. The antihistaminic drugs do not affect gastric acidity.

We have never used in these parts, as far as I know, roentgen therapy for the reduction of gastric acidity. Have you had experience with it, Dr. Gould? If it works, and they say that it does in Chicago, I wonder whether or not it slows down pancreatic function. How would it selectively inhibit gastric glands and skip pancreatic glands?

When peptic ulceration, particularly duodenal ulceration, resists the regimens that I've mentioned we may say that the ulcer is "intractable." If the surgical complications of hemorrhage, obstruction, and perforation can be excluded what medical complications may we look for?

As Dr. Mellinkoff suggested, we should look into the emotional fields of persons whose ulcers resist our simple treatment. The patient's ulcer may really not be so intractable; it may be that he has an intractable wife. When she is "reformed" or when he has been taught to accept her as she is, his ulcer may heal readily. A new boss has been known to relive the symptoms of ulcer better than drugs. Then again intractability may result from failure of the patient to follow treatment prescribed. If one produces a pH of 4.0 or higher in the stomach and if he keeps it there the chances are one will make his patient comfortable. The average ulcer heals in three or four weeks; then one may broaden the diet to a smooth one, keeping up the intermediate feedings and continuing this program six to nine months. The patient will often voluntarily continue with the principles of the smooth diet indefinitely. I always urge those patients who have stopped smoking to continue to get on without tobacco and on every ulcer patient I pin a White Ribbon and I ask him to remain on the "Wagon". Then, after such a so-called "cure," every September and every March and when the patient is under stress and strain he should return to the use of intermediate feedings and of alkalis.

PSYCHIATRY

JACOB E. FINESINGER, M.D.

Before beginning with my personal discussion I would like to say a few words about some of the remarks brought up by the other discussants. I think it is not too bad if you have an intractable wife because it is conceivable you can get rid of her, but if you have an intractable problem inside of you it is not so easy to get rid of it, and this may be a major source of difficulty.

There is a certain amount of evidence these days that emotions, such as anger, hostility, and resentment play a very important role in affecting certain gastric functions. You all know that Harold Wolff and his colleagues clearly demonstrated that these emotions can be an important factor in producing hyperemia, hyperactivity and hyperacidity.

Dr. Avery Weisman and myself in a study of the Massachusetts General Hospital attempted to investigate the symptoms, emotions, and personality of a series of 60 patients with peptic ulcer—established by x-ray diagnosis (Table I).

In working with patients, it is possible to have patients tell us details about themselves which are very specific. This first study was based on the observations of a variety of patients. We tried to determine the incidence of frank psychoneurosis. This was done by interviews and by questionnaires. In this study psychoneurosis was defined in terms of symptoms; if you had certain symptoms then you had a psychoneurosis. In the series of fifty-nine patients with peptic ulcer we could make a diagnosis of frank psychoneurosis in over sixty per cent of patients. In contrast, in a series of one hundred patients with fatigue, and this is fatigue in patients whose physical examination was negative, the incidence of psychoneurosis was way up over ninety per cent. In the series of sixty-two patients with

TABLE I

Incidence of Frank Psychoneurosis

DIAGNOSIS	NO.	INCIDENCE
Patients with Fatigue	100	94%
Peptic Ulcer	59	64%
Atopic Dermatitis	62	22%
Healthy Sailors	37	18%
Healthy Pilots	150	18%

atopic dermatitis the incidence was way down, about twenty-two per cent. As controls, we have two groups: a group of healthy sailors and a group of healthy pilots. In these two groups the incidence of frank psychoneurosis was somewhere between fifteen and eighteen per cent. This would indicate that there was a great deal of frank,

TABLE II

Exacerbations in Peptic Ulcer (60 Patients)

SITUATIONS		PREDOMINANT EMOTIONS	
Work	36%	Anxiety	42%
Family	24%	Hostility	40%
Social	22%		

TABLE III

Onset of Peptic Ulcer (60 Patients)

SITUATIONS		PREDOMINANT EMOTIONS	
Work	54%	Anxiety	36%
Family	26%	Hostility	32%
Social	20%		

diagnosable psychoneurosis in our series of patients with proved peptic ulcer (Table II).

In the patients with peptic ulcer we were concerned with the situational and emotional factors present when exacerbations occurred.

We divided the types of situations into three kinds—work situation, family situation and social situation. The data show that the greater incidence of exacerbations occurred in work situations. As to the kind of emotions present during these situations, anxiety occurred in well over forty per cent and hostility also to about the same degree (Table III).

It is easier to study exacerbations than it is to study the onset. We did see many patients at the onset of their illness. In studying the history of these patients we found three types of situation at the onset—work, family, and social work situations. The same types of feelings, anxiety and hostility, were present in about the same percentage as during exacerbations. This would make us believe that whether we are dealing with exacerbations or the onset of peptic ulcer, the same situational and emotional factors were present (Fig. 1).

In studying the personality of these patients, we found in about two-thirds of the patients their personalities could be characterized as overactive, meticulous, overambitious, self-reliant, rebellious, and resentful. However, there were a smaller group of patients in whom one found a different sort of personality. These were compliant, conforming people who seemed to seek support and security. They were underactive, submissive and docile. We can distinguish people

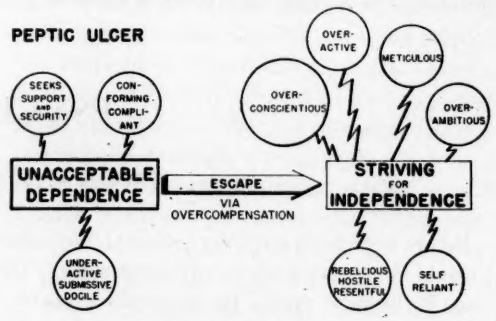

FIG. 1

who strive for independence, and who are ambitious in contrast to others who are dependent and have trouble in accepting their dependence. In attempting to explain this contrast, we fall back on a theory that maybe the basic personality type is the dependent type. These individuals attempt to compensate for their dependence by becoming overactive and ambitious. It is important to remember this is a theory.

The problem that comes up is, is there any relationship between the two types? In doing intensive psychotherapy with peptic ulcer patients one has surprises. You begin with an active ambitious type of person and during the course of treatment, especially if you go into difficult personality areas, you find that the patient changes. He becomes more dependent, more compliant, so we wonder, maybe this theory might be worthwhile thinking about.

Diagrammatically, this may be illustrated by circles representing the descriptive facts and the theory that one type of behaviour is a compensation for the other (Fig. 2).

It brings up the problem as to how these factors affect patients and how they affect doctors in working with patients. I was thinking as Dr. Mellinkoff made his apt remarks that it may not be so important what the patient is eating as to what is eating the patient. Sometimes what is eating the doctor may be important too. Basically what we had been inclined to do in therapy and treatment is to do something about these personality trends. We would like to moderate the patient's ideals if possible, we'd like to tone him down so he won't be quite so overactive. If the patient is dependent, we would like to make him accept his dependence if possible.

In doing any type of psychotherapy with patients, whether it be insight, relationship or support, these personality traits may get in the way of treatment. A patient who is rebellious with the outside world will also rebel when the doctor suggests that he do certain things. This hostility and resentment may come into the doctor-patient situation and complicate the doctor's problem in doing therapy. The same thing may happen with people who are inclined to be underactive. They tend to become more underactive and this poses a problem which I am sure you are all familiar with in working with patients who have peptic ulcer. These personality characters operate whether you are doing psychotherapy or medical therapy or even surgery for that matter.

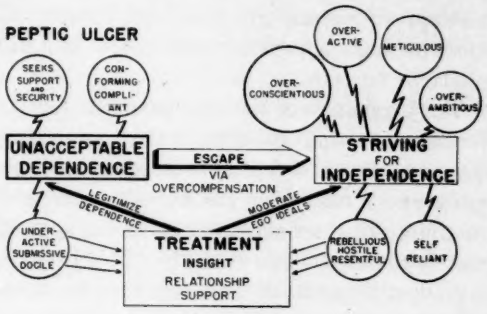

FIG. 2

I think it would be reasonable to say that there is enough evidence to indicate that emotional factors can be important both in precipitating exacerbations and in the onset. We also believe these personality factors are very important in treatment situations. We think they are good evidence to indicate that in the group of patients with peptic ulcer the personality types described above occur more frequently than other types. Why this is so is a question for discussion.

RADIOLOGY

DAVID M. GOULD, M.D.

I wish to comment on the point Dr. Howard brought up concerning x-ray treatment for ulcers. I know that x-ray treatment has been recommended for practically every existing medical ailment, however, the radiologist must keep a perspective based on rational therapy. While it may be true that sufficient roentgens delivered to the upper abdomen can decrease gastric acidity and the secretion of pepsin, the doctor must bear in mind the price paid for achieving this end. I believe the price is too high. The liver, the pancreas, and the spleen would be unfavorably affected by the dose of roentgens necessary to decrease gastric acidity. The possibility of a roentgen induced cirrhosis or pancreatitis is too great a price to pay for the alleged cure of benign ulcers. I would not recommend roentgen therapy for gastric or duodenal ulcers.

My interest in peptic ulcers stems both from a professional and personal viewpoint. Fifteen per cent of my radiologic colleagues have duodenal ulcers. One of my closest associates, who was the epitome of emotional stability and perfectly asymptomatic had his ulcer ushered in by perforation. Since this event I have made no attempt to conceal my emotions. I hope that Dr. Finesinger approves of this course as a prophylactic measure.

The popularity of the roentgenologic method for demonstrating ulceration in the upper gastrointestinal tract is definitely increasing. Only four years ago I remember the average number of gastrointestinal series each morning was approximately fourteen. Since that time there has been a gradual increase so that now twice as many examinations are being made of the upper gastrointestinal tract and generally for the purpose of demonstrating an ulcer or carcinoma.

The radiologist concerns himself with visual evidence of the anatomical site and the gross pathological nature of the lesion. He is not primarily concerned with either the etiology or the histology of the lesion. If an ulcer crater is demonstrated and its size, position, and gross character is described, then the radiologist feels his task has been accomplished. From this point on, anything the radiologist says is in the realm of educated guesswork. He may know, for example, that very rarely does primary carcinoma involve the duodenal bulb, and therefore an ulcer crater in this portion of the duodenum is in all likelihood a benign peptic ulcer. He may also know that ulcers on the greater curvature of the stomach are rather frequently benign and therefore a greater curvature lesion would be viewed with the grave suspicion of malignancy. He knows the majority of ulcers on the lesser curvature side of the stomach, may be benign. However, statistical possibility of carcinoma is great enough that he must always entertain in his impression, the question of a malignant neoplastic process. The experienced radiologist is cognizant of many pitfalls. He knows that diverticula of the stomach usually located near the cardiac orifice should not be confused with ulceration. He also realizes that a scarred deformed duodenal bulb may result in an outpouching of one of the fornices of the bulb producing a pseudo diverticulum formation and that this should not be confused with ulceration. It is true that with thoroughness and experience, educated radiological guesswork can be of great clinical aid. However, I wish to underline the fact that the radiologic method cannot differentiate benign and malignant lesions.

For the diagnosis of ulceration the roentgenologist uses the roentgen ray in two ways. The first is the dynamic direct fluoroscopic method and the second is the detailed permanent record taken on the x-ray films by the roentgenographic apparatus. Both of these methods are necessary complements. The radiologist who uses the fluoroscope alone puts himself in a precarious position because the limitations in the brightness of the image and the sensitivity of the eye make it impossible for him to see great detail. On the other hand, the radiologist who depends upon films alone does not appreciate peristaltic activity, flexibility of the wall, and small ulcer niches which can be observed only in one particular projection and with the exertion of a specific amount of pressure here.

There is a great deal of art involved in fluoroscopy. In addition to a well grounded routine designed to exclude any gross organic lesion of the esophagus, stomach, and duodenum, the experienced radiologist develops a keen hunting eye. The way barium splashes down the lesser curvature, a slight aberration of the intricate mucosal pattern, a little hesitation in the peristaltic wave, a slight increase in rigidity of the stomach wall are signs to him that an ulcer or neoplasm may be lurking.

Classically, ulcers in profile form a niche or positive filling defect showing barium jutting out from the wall or lumen of the stomach or duodenum. Theoretically a carcinoma grown into the lumen of the stomach forms a negative filling

defect before an ulceration occurs. The classical case may be easy to differentiate, but most cases do not appear to be of the classical variety.

In addition to the silhouette type of visualization of an ulcer crater, I must mention that many ulcer craters, particularly in the duodenum can only be visualized "en face" or covered by the anterior or posterior wall. With a benign ulcer one frequently sees spasm of the wall opposite the ulcer, forming an incisura. Contraction of an ulcer tends to form radiating folds converging toward the crater. All too often, particularly in the duodenum, one does not demonstrate the crater. However, a scarred, contracted, and deformed bulb is accepted as excellent evidence of a chronic duodenal ulcer. Activity must always be judged upon clinical grounds. If we add up all our impressions of duodenal ulcer, I would estimate that we demonstrate 40% with an actual crater. The remainder have puckering, scarring, deformity, and pseudo diverticula formation. Many radiologists claim they can demonstrate a much higher percentage of ulcer craters.

There are three complications frequently seen in peptic ulcer patients. These complications are 1) perforation, 2) hemorrhage, 3) stenosis. Simultaneous occurrence of any two of these complications is quite rare, however, it is not uncommon to have a patient who presents himself with one complication, for example perforation, and gives a history of episodes of either hemorrhage or perforation.

Perforation of a peptic ulcer is a general radiologic problem. It certainly does not lie within the jurisdiction of the gastrointestinal fluoroscopist. There have been cases reported of the radiologist actually seeing perforation occur under his very eyes. The barium wells out from the lumen of the stomach or duodenum into the peritoneal cavity. This catastrophe I have never seen, nor do I relish the though of seeing one.

The perforated viscus is usually considered by the radiologist when he sees free gas in the abdomen. When one suspects a perforated ulcer it is customary to request a flat and erect film of the abdomen. On the erect film free air collects under one or both leaves of the diaphragm. If the case is not diagnosed, or the surgeon delays treatment, then one seeks radiologic signs of general peritonitis. If a paralytic ileus develops, one sees dilated gas and air filled loops of bowel. If free peritoneal fluid is present the soft tissue detail of the abdomen is obscured and the loops of bowel show separation.

If a patient has a bleeding ulcer, it presents a most difficult problem to the radiologist. No one can dispute that massive gastrointestinal hemorrhage is the most concrete evidence of an organic lesion. The radiologist looks for esophageal varices, he looks for a hiatus hernia, looks for neoplasm, and he looks for gastritis as well as ulcerations. In cases eventually proven to have a peptic ulcer it is a puzzle to me how frequently the lesion is not demonstrated on the first examination. The handicap of the very ill patient and non-manipulative examination may play some role, however, I believe that other factors exist. Perhaps a blood clot or marked inflammation of the mucosa hide the actual crater. Eventually with repeated examination I would estimate that we demonstrate the actual site of bleeding in little more than half of the patients.

It is probable that many cases of massive hemorrhage do not have a discrete ulcer but have gastritis. I have seen surgical specimens of stomachs with markedly enlarged gastric folds with a great number of superficial erosions. The diagnosis of hemorrhage due to gastritis lies within the province of the gastroscopist rather than the radiologist.

The last complication which I shall discuss is the stenosing ulcer. This condition occurs almost exclusively in the pylorus and duodenal bulb. The patient usually gives a history of a long standing peptic ulcer. Pathologically there is much scarring, deformity, and fibrosis which contracts the duodenal bulb to form a very small lumen. Radiologically we frequently see a very large stomach sometimes reaching huge

proportions and holding a gallon or two of fluid and food particles. Peristalsis may be very acute, or may be entirely absent. If the stenosis is of a high degree, the radiologist may find barium sharply contained by the pylorus and he may be unable to visualize the deformed duodenal bulb even with numerous observations spread over a period of hours. In cases such as these it is customary to obtain 5 hour and 24 hour films to see how much residual barium remains in the stomach. In my experience I have found that a stenosing ulcer is more apt to give a large stomach rather than an antral carcinoma obstructing the pyloric gateway.

A few traditional conceptions and misconceptions should be mentioned. I agree with Dr. Howard that the lesions close to the pylorus may be benign or malignant. There is an old radiologic adage which states that "within the first 3 cms. proximal to the pylorus the lesion is always malignant." I do not believe this adage. There are a great many benign lesions in the pre-pyloric region, however, the incidence of malignancy is high enough to warrant an exploration. Another old tradition concerns the size of ulcer craters. It has been frequently stated that if an ulcer is very large, larges than 2.5 cms., then it is in all likelihood malignant. I do not believe that. Some of the largest ulcers that I have seen, measuring 4 to 5 cms. in diameter, have been proved benign.

I wish to emphasize that the prime goal of the radiologist is to demonstrate the anatomical location and the gross pathology associated with peptic ulcer. In the last analysis we cannot definitely distinguish a benign from a malignant ulcer. However, even with this limited goal we are constantly striving to refine our methods of making a definitive diagnosis of ulcer. Better contrast media, better spot film devices, more precise technique, and eventually fluorescent amplification will greatly enhance the accuracy of the radiologist.

SURGERY

C. REID EDWARDS, M.D.

I am sure there are many surgeons in the audience who would relish the opportunity of getting up and defending the position of surgery with regard to peptic ulcer. So far, this has been a very placid meeting. Dr. Fort called me, and when giving this assignment said there would be a lot of fur flying. Well, I don't see any evidence of it. I think it has been a very friendly meeting and I hope it continues to be so. The fact an opportunity has been given the surgical side to say something, means that there are some people who live in an "ulcer state" who can't get along under medical supervision and psychiatric talking.

Dr. Stone referred to some people who make the headlines, and even some prominent people who are victims of peptic ulcer, some proven, some not. Unequivocally William Shakespeare was a brilliant man, and some lines of his come to my mind. I don't know whether he had an ulcer or not. There weren't any x-ray men to diagnose it; there weren't any internists to treat it; there weren't any surgeons to remove it, and he just had to live with it because a psychiatrist couldn't talk him out of it. He wrote: "There is a tide in the affairs of men which if taken at flood leads on to fortune, omitted—all the voyage of their life is bound in shallows and in miseries." So, there was a definite place even in the mind of Shakespeare for surgical intervention, possibly in ulcers.

I am very glad to hear an internist condemn the gastric meal. I have never seen the test do any good. The patient who has a painful ulcer

isn't awakened at two o'clock in the morning or later, or he doesn't have to leave his schoolroom in the middle of the afternoon because he has had a meal. He has pain on what country folks describe as "an empty stomach." I think a test meal with or without histamine or alcohol stimulation (and the meal itself is a stimulation) to prove that the patient has acidity, does not add to our knowledge of peptic ulcer. We know that he has hyperacidity, in a great majority of cases. What are we going to learn by giving him a test meal or alcohol or histamine or other stimulating agents except to increase his misery. I think we have to look at the patient who has an ulcer very much like we do the patient who has a carcinoma. I'm not as interested in what the pathologist tells me, as I am in observing how the patient behaves. One patient is operated on for carcinoma, and the pathologist gives the worst prognosis possible. That patient goes for ten or fifteen years without recurrence. Another one comes along with an apparently similar growth. A very hopeful prognosis is given by the pathologist and the patient is dead in six months with extensive metastasis.

A patient who has a peptic ulcer with moderate hyperacidity and a normal or slightly above normal secretion of gastric juice is not in the same clinical state with a patient who has a tremendous outpouring of gastric juice and a relatively low hyperacidity.

For instance, a big, healthy man, twenty-three years old, weighing one hundred and eighty pounds, a State policeman, suddenly collapsed. He had a gastric hemorrhage, was taken to a hospital, transfused, and gotten in good condition. The x-ray physicians were not sure, but they thought he had a duodenal ulcer. A month later, the same thing was repeated. He was again transfused and gotten in good shape. X-ray studies showed a small ulcer. Continuous overnight drainage obtained eleven hundred cubic centimeters of gastric juice with free hydrochloric acid of one hundred and thirty. That is a tremendously large quantity of fluid. Many patients with an acute peptic ulcer will put out as much as fifteen hundred cubic centimeters of gastric juice in twelve hours even without stimulation. That type of person wakes up three or four times during the night complaining of pain. Continuous gastric drainage gives a very much better idea of the clinical behavior of the gastric mucosa than does a test meal.

There are a number of reasons for operating on patients with gastric ulcer, and one of them is bleeding. The patient with an active hemorrhage frequently gives an ulcer history of a number of years duration. Why do we have patients with such an extensive hemorrhage improve after transfusions, and then quickly become worse and have repeated hemorrhages? It is well demonstrated in the patient having duodenal ulcer with massive hemorrhage and subsequent operation. Pathological sections show the artery with an unorganized blood clot, thereby illustrating perfectly the old definition of a consecutive or reactionary hemorrhage. As soon as the blood pressure is built up and since the artery is sclerotic with no organization of the clot, blood flows out and the patient has another massive hemorrhage. There are too many cases which have gone through many hospitals in the past two years requiring fifteen, twenty, even twenty-five pints of blood to carry them over this episode.

A gastric ulcer with chronic crater base has fibrosis with sclerotic arteries. Such an ulcer will produce the kind of hemorrhage that we see so frequently in this type of patient. Any ulcer in the stomach presents the possibility of perforation and, of course, hemorrhage. A large ulcer is always interesting to a surgeon. He wonders what prevented the patient from having a perforation hours and days before its occurrence because at the site of the perforation there is a total absence of tissue oftentimes large enough to pass a five cent piece or even a quarter through it.

An ulcer on the lesser curvature is notoriously dangerous from the viewpoint of hemorrhage. When that type of ulcer is seen in the patient

with hypertension, it is, of course, very much more likely to produce massive hemorrhage. A former nurse from another State, diagnosed as having had a duodenal ulcer twenty-five years previously, developed malignant hypertension about a year before we saw her. A bilateral Smithwick operation had been performed. Patients with vagotomy or sympathetic operations for control of high blood pressure become less aware of symptoms. This woman suddenly began to bleed and in the course of two days required seventeen pints of blood to get her into condition for resection. At operation she presented a picture of multiple ulcers and very active bleeding. Multiple ulcers in the stomach are not at all uncommon, and, of course, there are a number which are both in the duodenum and in the stomach. If patients could have an x-ray examination weeks and months before the development of complications, maybe x-ray people could demonstrate the location of the ulcers. However, many people who develop active hemorrhage have not had previous examinations. These patients present a complex problem to the internist and surgeon alike because of the emergency of the situation.

TABLE I

Total Peptic Ulcers, University Hospital, for 5 Years—January 1, 1946 to December 31, 1950

(586 peptic ulcers represent 0.8% of a total of 65,425 hospital admissions.)

	CASES	PER CENT
Duodenal	384	65.7
Gastric	189	32.2
Marginal	13	2.2
Total	586	
Total Deaths	41	6.9

During a five year period there was a total of 586 peptic ulcer cases admitted to the University Hospital, or less than one per cent of the total admissions. Classifying the 586 ulcer cases according to location reveals that there were 384 duodenal ulcers, or 65.7%; 189 gastric ulcers, or 32.2%, and 13 marginal ulcers, or 2.2% (Table I). Of this entire series of 586 ulcer cases, 322 were treated medically with an over-all mortality of 7.8%, and 264 cases were treated surgically with a mortality of 6.1%. In both series, specific mortality rates varied with the location of the ulcer (Table II).

The mortality rate of those designated as medical was not due to the ulcer alone in a number of instances. Other serious conditions justified medical supervision and during the course of their hospitalization they succumbed. Postmortem examination frequently revealed the presence of an ulcer as being coincidental.

TABLE II

Treatment of Total Ulcer Series

(Surgical, 45.1%; Medical, 54.9%)

	SURGICAL CASES	MEDICAL CASES
Duodenal	138	246
Gastric	116	73
Marginal	10	3
Total	264	322
Total Deaths	16	25
Mortality	6.1%	7.8%

TABLE III

Presenting Symptom or Complication—Surgical and Medical Treatment

	TOTAL	SURGICAL	MEDICAL
Pain	352	148	204
Hemorrhage	134	26	108
Perforation	82	76	6
Obstruction	18	14	4

These cases were divided according to the presenting symptom or complication. General subdivisions included pain, hemorrhage, perforation and obstruction. The predominant symptom in both the medical and surgical groups was pain, with 134 of the total peptic ulcer group having evidence of hemorrhage; 82 with perforation; and 18 with obstruction. Pain was the predominant reason for treatment in 352 of the total cases (Table III).

Surgical treatment instituted in these cases resolved itself into subtotal gastric resection, vagotomy, gastroenterostomy, simple closure of the perforation, or a combination of these procedures. The majority, or 177 cases, of the surgically treated patients received subtotal gastric resections, with a mortality of 6.7%. Vagotomy alone was done on 3 cases with a zero mortality. Gastroenterostomy was done on 11 patients with a mortality of 9.1% (Table IV).

Gastroenterostomies, of course, were reserved for cases too desperate to permit other types of operations. Something was demanded to overcome vomiting. This group of patients represented many derelicts. It is a difficult group, and even though gastroenterostomy is a rather simple operation, a high mortality must be anticipated because of a high urea and poor kidney function.

TABLE IV

Surgery Performed—264 Cases

PROCEDURE	CASES	DEATHS	MORTALITY
Resection	177	12	6.7%
Vagotomy	3	0	0%
Gastroenterostomy	11	1	9.1%
Closure of Perforation	64	3	4.7%
Combined Procedures	9	0	0%
Total	264	16	6.1%

Closure of perforation was done on 64 cases with a mortality of 4.7%, and combined procedures, such as vagotomy and resection, or vagotomy and gastroenterostomy was done on 9 cases without mortality.

From a surgeon's standpoint it is extremely interesting to analyze the marginal ulcers. The marginal group having had previous surgery should help us evaluate certain inadequacies which may occur. It is interesting to note that the length of time between the original surgery and re-admission for marginal ulcers varied from 2 months to 17 years. In the marginal group the average elapsed period of time was 6.5 years.

Despite the recommendations for vagotomy alone for the control of marginal ulcer or of atropine or banthine or some other preparation, many cases of marginal ulcer are not going to respond to any form of treatment other than surgical excision. Of course it represents one of the most disappointing groups encountered, since previous surgery, performed to cure an ulcer, has become complicated by the development of a marginal ulcer. Antecedent surgery which had been performed on these cases comprised subtotal gastrectomy 6 cases; gastroenterostomy 6 cases; gastroenterostomy and vagotomy 1 case. Three of the marginal ulcer cases were treated adequately by medical means and 10 required surgical intervention (Table V). The predominant symptom in the marginal group was pain. Four of these cases presented complications, 2 of hemorrhage, 1 perforation, and 1 case presented a gastrojejuno-colic fistula.

TABLE V

Analysis of Surgery Performed on 10 Cases of Marginal Ulcers

In addition, 3 cases were treated medically without mortality.

PROCEDURE	CASES	DEATHS	MORTALITY
Resection	6	1	
Vagotomy	2		
Closure of Perforation	1		
Combined Procedures	1		
Total	10	1	10%

It is now believed by surgeons over most of the country, that the end results of surgery as applied to a duodenal ulcer are dependent almost entirely on removal of enough gastric mucosa to guarantee a tremendous decrease if not a total decrease in the amount of acid secreted. Marginal ulcers are going to be seen in patients where deficient operations are done.

In reading reports from many clinics over a period of years, it will be found that the incidence of marginal ulcers has been reported from sixty per cent down to a minimum. Many clinics a few years ago, were reporting fifteen to twenty-

five per cent when they were doing gastroenterostomies.

In patients having a total or subtotal gastrectomy, meaning thereby the removal of at least seventy five per cent of the stomach, the amount of acid secreted following it is practically negligible. Whether or not this is the right thing to do is still in doubt. Certainly the reports from many clinics now show that the removal of seventy per cent of the stomach gives almost three times the number of satisfactory results than can be obtained by any other method, including the medically treated.

There is no difference in the attitude of surgeons and internists now, in regard to peptic ulcers than there has been. Somebody said not long ago that the medical people try to control the ulcer state and the patient, and to keep the patient from the clutches of the surgeon and the postmortem table. He also stated surgeons try their hardest to take the patients from the medical people and cure them, and that is what we hope to do.

QUESTION AND ANSWER PERIOD

DR. STONE: This first question is really presented in three parts, but it really is one question, and although it is addressed to Dr. Mellinkoff, I would like to see what Dr. Howard and what Dr. Finesinger have to say about it.

Q. Has the existence of peptic ulcer notably increased in this country in the last twenty years?

Is this increase especially noteworthy in the negro population?

If there is an increase, do you attribute it to the intensification of pressure in the development of our political and economic environment?

DR. HOWARD: Yes, I believe that the incidence of peptic ulceration has increased and, since I feel that psychic factors have much to do with peptic ulceration, I attribute the increasing incidence of the disease to our complex and often frustrating economic and social environment.

It does seem that there has been a striking increase in the number of peptic ulcers seen in negro males. I'm inclined to the belief that conflict with environment plays an etiologic role. The young colored man who leads a simple life on a farm in Mississippi is probably less likely to have an ulcer than is his brother who goes to work in a factory in a northern city and who develops ambitions and resentments.

DR. FINESINGER: I have the impression that ulcer has increased in the male, I had a chance to go over some statistics. Fifty or seventy-five years ago ulcer was more common in female patients than it is today. I'd like to make one comment about the increased pace of living. The more we learn about ulcer—and about other psychosomatic disturbances too—the more we are inclined to believe the particular kind of stimulus, which may be responsible for reactions of this type, is a rather highly personal stimulus. It is the person's individual problem, his personal problem, his conflict, the kind of adjustment he happens to make, that is important in bringing about reactions of this kind. Whether those reactions occur more frequently in our current civilization is very hard to tell. I cannot add very much more to that.

DR. MELLINKOFF: As to the increase in the incidence of peptic ulcer, I think almost all the statistics that have been accumulated so far are open to a good deal of question because of the greater accuracy of diagnosis now as compared with twenty years ago. In Ivy's book on Peptic Ulcer (Ivy & Grossman), it is claimed that autopsy figures show that the incidence of gastric ulcer has increased in the past twenty years and that the incidence of ulcers among women has

increased. I don't recall any figures about ulcers in the negro population, but again I think the question of frequency of diagnosis would bear upon the statistics. I suspect probably there has been some increase in incidence of peptic ulcers. At least Ivy's figures gathered from all over the world would tend to bear that out. And as to whether that is due to increased pressure of modern living, I'm afraid I will leave that to Dr. Finesinger.

DR. STONE: One comment I might make in regard to the question of negro population. When I was an interne a good many years ago, it was almost unheard of to find a patient of the negro race with duodenal or gastric ulcer. It was really a great curiosity. At the present time, judging from the occurrence of the disease in Johns Hopkins Hospital, it is by no means uncommon, so that while I haven't any actual figures I have a firm impression that whatever environmental or other factors are of influence, in the occurrence of ulcer, they are beginning to affect the negro population, the negro race just as they do the white race. In other words, there has been a response of a similar nature which wasn't present forty or fifty years ago.

FROM AUDIENCE: May I make a comment? This is really not my business but I remember Dr. Halsted's work on peptic ulcer which was from figures checked in an Army Camp in North Africa during the last war. Apparently there were ulcers found in the negro patients. I forget the exact percentages, but I had the impression from the study that the type of ulcer found in these negro patients was primarily gastric rather than duodenal.

Q. DR. STONE: The next question is addressed to Dr. Howard particularly. Why the seasonal exacerbations in the spring and fall?

DR. HOWARD: I have no explanation but I'm sure that they occur. I know of no theories about them. I think it must be something like the weather and rheumatism; it is not understood. We all believe our patients when they say their rheumatism is worse in bad weather but we aren't able to explain why that is so.

DR. STONE: Does anyone else have any comment?

FROM AUDIENCE: I'd like to recall Dr. Friedenwald's work on this right here in Baltimore many years ago. He had an idea that infection had a tremendous influence on these peptic ulcers. In fact, it is mentioned in a number of text books that the seasonal upsurges, which he attributed to infections in the mouth and oral pharynx some of the text books attribute to seasonal respiratory infections.

Q. How long should antacid and dietary treatment be continued in patients who have been operated upon or have recovered under medical treatment and are symptomless?

DR. HOWARD: I think a reasonable time for careful medical management is about nine months. Then patients should try to live on a bland or smooth diet, limiting tobacco and alcohol forever. I always tell my patients that they have a chronic disease which may relapse. After surgery, I think three months on a bland diet is fair. They had their operation to get well. I say that a short period of dieting is a kind of insurance. Some surgeons will disagree with me, I know. They'll say, "Go ahead and eat everything after your operation, you had it so that you could eat everything!" But I ask them as a rule to be "good" for three months and then they can have carte blanche and eat as they wish.

DR. STONE: Dr. Edwards, do you want to comment on that slur on the medical profession —on the surgical group, I mean?

DR. EDWARDS: I think we should operate on people with the idea of curing them. I don't believe that any operation should be done for gastric or duodenal ulcer until the patient has had an opportunity to get well or to make marked improvement under medical supervision, but when the patient has reached the point that he cannot endure life any more then he should come to surgery. Once he has come to surgery the adequate thing should be done and then I don't think he should be a cripple. I don't think it is necessary to keep him on a rigid diet. He should be permitted to eat what he wants if it agrees

with him, and if he likes it, and he can get it in these days of high prices.

Q. DR. STONE: I hate to present a divided front from the surgical wing but I can't quite agree with that point of view. I feel that there's a question here that is later going to be directed to Dr. Finesinger. I feel the patient who has a peptic ulcer simply presents a symptom of an underlying dyscrasia, and that the removal of ulcer or the removal of part of the stomach or secretory mechanism of the gastric juice doesn't essentially convert that underlying dyscrasia into normality. We do know alcohol, tobacco, nervous strain and things of that sort are trigger incidents that set off the underlying disorder and I think that a person who has had a gastric resection may be cured of that ulcer, but he isn't cured of his underlying trouble and he ought to be regarded as a patient for the rest of his life. Now this question is along the same line and is for Dr. Finesinger. Granted that the psychiatric approach in therapy may be of value in diminishing incidence and intensity in ulcer development, do you think it is possible to modify effectively the real underlying psychosomatic basis on which these symptoms develop? In other words, can you alter the disorder which gives rise to these symptoms? You can stop the irritants and stimuli, but can you change the underlying trouble?

DR. FINESINGER: I think if I personally could change the underlying trouble, I'd be around collecting Nobel prizes instead of sitting here. One of the most troublesome and vexing problems that not only we psychiatrists have but also doctors and politicians and everybody else in this world has, is to change the basic personality of people. We do see changes in the underlying personality in many patients. This always reminds me of a story of Freud. Someone once asked him "why is it that psychoanalysis takes so long?" He said: "I don't know, you better ask God, he made the patients, I try to cure them and I find it takes time." At present our methods of basically changing people and basically changing this ulcer type of patient are not too good. On the other hand, what is interesting is that a patient can have a certain type of personality for twenty-five years and then on a certain day apparently something starts and he begins to get an ulcer. I think one can differentiate between what you may want to call personality, and other events which occur in a patient's life. If we can do nothing else, no more say, than even controlling some of these precipitating factors, we think we are along the way. But another point I'd like to make too, is that when we speak about a patient or individual having a certain kind of personality, it is wise to remember he has that personality in a given situation. The so-called intractable wife isn't intractable every day in the year. Some days she is and some days she's not. What are the factors which make her more or less intractable? We believe that is the first area to approach in working with patients. It is quite possible for people to behave differently in certain kinds of doctor-patient relationships than they do in others. I cannot refrain from making a comment in reference to something Dr. Edwards hinted about. I haven't known a surgeon yet, and maybe I have a lot to learn, who doesn't use talk somehow or other. In spite of the fact that he may use other weapons, he also uses talk. Furthermore, I haven't known a patient yet who doesn't use talk so that fact remains that we all use talk. The question is can we use talk in a productive way, in a way which is going to help patients? I'm sure Dr. Edwards wouldn't mind for one moment if he could cure all peptic ulcer patients even with talk.

Q. DR. STONE: Dr. Finesinger, I don't want to overwhelm you at once, there are several other questions here. I'm not going to ask you to try them all. Here is one. Since passive dependence and striving for independence are commonly found in our culture, is it not possible the ulcer is a fortuitous finding based on the nature of the end arteries? Are not the same personality factors found in other so-called

psychosomatic entities like ulcerative colitis and in neurotic characters who do not develop peptic ulcers? In other words, I think the point of that question is that a great many people have these personality peculiarites that do not develop ulcer and isn't it necessary there be a combination of some local circumstance that leads to ulcer in one patient and something else in another of the same psychic type?

DR. FINESINGER: I think no one would ever assume that this is not the case. When people began to study these psychosomatic conditions, they had the idea that they would find a different personality type in every type of psychosomatic disturbance. What seems to be emerging is that there is a certain personality type that you would find most frequent in people who have hypertension, people who have mucous colitis, and people who have coronary diseases. There is another type of personality, the one mentioned in connection with ulcer, which one also finds in asthma. We would be inclined to believe before a person is able to have an ulcer that in addition to this type of personality a whole variety of other factors must be present. He may have to have a certain kind of stomach I suppose, and a certain kind of central nervous system. We'd be inclined to think there are a whole series of factors which apparently must be present before a patient gets any one of these psychosomatic disturbances. The therapeutic problem centers about the best way of dealing with the patient. We'd be inclined to be very practical and treat the factors in the patient that you can do something about. Sometimes surgery is indicated and sometimes we think talk is indicated. Our efforts at the treatment are determined by our information as to what is useful in the areas in which we can work effectively.

Q. DR. STONE: Dr. Gould, this question is for you. How dependable is the observation of gastric ulcer under treatment in determining whether improvement is taking place or not?

DR. GOULD: I do not think that improvement in an ulcer crater is a dependable criteria to rule out malignancy. I have seen too many so-called benign gastric ulcers which appear to have improved clinically and radiologically, finally turn out to be malignant ulcers.

Q. Is it dangerous to fluoroscope a patient with recent gastrointestinal bleeding?

DR. GOULD: The consensus of modern opinion is that fluoroscopic examination of a patient with a recent gastrointestinal hemorrhage is not dangerous. There are large series of patients with acute gastrointestinal hemorrhages studied within 48 hours of the onset of the hemorrhage. One must take elementary precautions regarding the volume of blood loss and shock. Another necessary precaution in acute bleeding cases is that the fluoroscopic examination be non-manipulative. Theoretically it is true that with vigorous manipulation an ulcer that has been bleeding recently may dislodge a clot and start bleeding afresh. As a general rule the radiologist handles bleeding cases as delicately as possible. I do not remember a specific case in which recurrence or aggravation of hemorrhage was caused by a non-manipulative fluoroscopic examination. I frequently advise non-manipulative fluoroscopic examination and gastrointestinal series as early as 24 hours after the onset of hemorrhage.

Q. DR. STONE: You said in your primary talk that there were several formerly generally accepted conventional statements with which you could no longer agree. How true do you think is the statement that ulcers of the greater curvature of the stomach are predominantly malignant? Is that a general statement that still holds true or have you seen reason to modify it?

DR. GOULD: In my experience that statement is true. Whenever I see an ulcer of the greater curvature of the stomach, I view it with the deepest suspicion. The vast majority of benign ulcers are on the lesser curvature or close to it. When I see an ulcer on the greater curvature I try to convey to the clinicians that neoplasm is a very likely basis for this ulcer.

Q. DR. STONE: Dr. Edwards, I have been holding in reserve a group of questions that were

submitted by one of our surgical friends and I'm going to take them one at a time if you don't mind. What is your opinion of the so-called conservative or non-surgical treatment of perforated peptic ulcer?

DR. EDWARDS: To condemn it.

Q. DR. STONE: Do you feel it has not enough value to be given serious consideration?

DR. EDWARDS: I think if one sees a patient who has never had any surgery applied to his stomach and he has a perforation of an ulcer of the stomach or duodenum, he is a candidate for surgery immediately. If one has had a previous perforation and now he comes in with pain in the upper right quadrant, sharp in character, and the x-ray examination shows a bubble of air which may be either a diverticulum of the duodenum or it may be a perforation, it is already sealed. Conservative treatment in that case may be worthwhile, but I don't believe it should be done on a frank perforation into the free peritoneal cavity.

Q. DR. STONE: I'd like to sharpen up this matter a little more definitely because I think it is a thing that concerns everybody in this room. I would like to reinforce the opinion Dr. Edwards has just given. It seems to me not only there is no rational method in withholding operation but that it is an extremely dangerous thing to do or to advocate. Now this question I would like Dr. Edwards and then Dr. Howard to comment on. What are the indications for operation in peptic ulcers with massive hemorrhage and when should an operation if indicated be done?

DR. EDWARDS: I think a patient who has no history of previous trouble, and you can't get a history of an ulcer and he's a young person, you might be justified in treating him medically over a period of two or three days if during that time he shows improvement which is continuous and hemoglobin and blood count levels all show improvement. If however, he is an older individual, aged fifty or more, and has the history of a peptic ulcer and comes in bleeding actively, I think that he should get all that we are able to give him, plasma, blood, watch him. Make hematocrit readings, blood count, hemoglobin estimates frequently, and if, after the administration of three or four pints of blood his hemoglobin level hasn't been tremendously increased, I think he is a candidate for surgery. About two years ago, we had a great number of these cases in a short time and the resident and I sat down and figured how much blood we could have saved in that month if we had subjected these patients to an early operation, and the amount totaled something like fifty pints. I think we are wasting blood in people who have marked sclerosis of the vessel. The bleeding is nearly always from the pancreaticoduodenal or one of its branches. It is a terminal vessel in a crater. There is no chance in the world for it to contract. It is too sclerotic, and I think that earlier operation is indicated in these people. One of the reasons for it of course has been well explained in many articles, the escape of the patient's own blood into his alimentary tract results in a very tremendous increase in urea level and a state of uremia is frequently responsible for death in these patients. Now, you can feed blood to an animal and it will digest it very well, but a patient who loses a great quantity of blood into his alimentary tract has a high urea developed very rapidly. The urine output decreases very rapidly and you are inviting a greater toxic state. Add to that the necessity of an anesthetic and an operation and I think that is where our mortality stays high.

Q. DR. STONE: Dr. Howard, will you continue?

DR. HOWARD: I think Dr. Edwards and I see eye to eye on that. My rule is that bleeding ulcers in persons under fifty are never treated surgically for their acute bleeding. They will always stop. After bleeding ulcer patients have passed fifty—and that isn't a hard and fast dateline—is the time to change your course in their management. Surgery may be needed. I agree with Dr. Edwards. Keep the pressure up; give them transfusions. I usually treat them vigorously for about six to twelve hours. Then I stop the transfusions and see if they are holding their blood. If they

go into shock again, if the pulse goes to one hundred and twenty, if the hematocrit falls, I think they are candidates for surgery after more transfusions. There is nothing like putting a ligature on a vessel.

Q. DR. STONE: Dr. Edwards gets this question, this is a long one. If an operation upon a chronic ulcer of a non-bleeding type reveals it to be in the pyloric area and it is adherent and difficult to mobilize, which is the better procedure, simple gastroenterostomy alone; gastroenterostomy plus vagotomy; vagotomy alone; partial gastrectomy with the exclusion of the pylorus; make every effort to remove the ulcer anyway and perform a routine subtotal gastrectomy or perform some other procedure not mentioned? It is perfectly obvious that that calls for the writing of a text book on the treatment of chronic ulcer, but I am sure that the purpose of the question is a very valuable one for this audience, because at the present time and for an indefinite period in the past, there has been a constant flux in the surgical opinion as to just what is the procedure to use in this type of ulcer. As all of you know, there has been a recent new contender for favor in the form of vagotomy. Now I think the purpose of this question could be condensed somewhat in this form. With a difficult adherent ulcer, what principles would you employ in this treatment?

DR. EDWARDS: Dr. Stone has very largely answered this question because it is a problem which is being discussed by surgeons always. It will depend of course, on the general condition of the patient, that is, is he a good surgical risk or not? It will depend of course on the general condition and on the type of anesthesia you employ; it will depend on the amount of blood available for the use of the patient during the course of the operation; it will depend upon the experience of the surgeon and then it seems to me the safest thing to recommend in a case like that is for the surgeon to carefully evaluate anatomically the situation and not do anything which he cannot undo. Now, when an edematous and inflammatory mass involves a common duct and it may go on up to the hepatic ducts, any surgery directed towards removing that part is very likely to result in a biliary fistula and maybe a duodenal fistula. If the ulcer is penetrating deeply into the head of the pancreas, its enucleation is very likely to be followed by necrosis of the pancreas which will result in local abscesses and pancreatic fistula. I try to persuade our house officers who run into these cases, and try to follow such practice myself, that after evaluating it anatomically, to do the thing which anatomically can be done most safely. If it is to be a gastroenterostomy to relieve the patient of obstruction and you have a large calloused ulcer which has bled, the gastroenterostomy is not going to prevent other hemorrhages. It may be necessary to even open the duodenum and transfix the ulcer in order to prevent hemorrhage if you must leave it there. A text book would have to be written in order to emphasize in detail, but what I want to emphasize is that nobody can attempt to do a major operation on a difficult type of duodenal ulcer, go half way and then back out. It will result in necrosis, biliary and duodenal fistula and possibly a pancreatic necrosis and abscess.

Q. DR. STONE: Do you want to say anything at all about your views in regard to the value of vagotomy alone?

DR. EDWARDS: Vagotomy alone is not dependable, I believe. In this room Dr. Dragstead about three years ago, said gastric surgery would be of historical interest only. It is very interesting in going through his own clinic to find that many of the cases that he has reported and is working on all the time are kept in the hospital six and eight weeks as a part of the treatment, and I think there, the value of the internist and the surgeon and the psychiatrist are combined. It has been proven in too many clinics throughout the country that a vagotomy alone is not a satisfactory operation.

Q. DR. STONE: If x-ray and clinical evidence of an ulcer were found preoperatively, but at the

operation no ulcer can be found even after opening the stomach, is one justified in performing a gastrectomy and other definitive surgery and would the decision be altered if there has been recurrent hematemesis? The gist of that is, here is a case in which you expected to find an ulcer and didn't find it, what do we do about it?

DR. EDWARDS: If I opened the stomach and couldn't find it and the case had been worked up thoroughly, I would not remove any part of the stomach.

DR. STONE: I'd like to cite—this is not an occasion where cases ought to be cited, but in confirmation of what has just been said,—I'd like to cite a case which Dr. Howard knows about, of a patient upon whom I operated. He had sharp bleeding from the stomach, we thought, at least he vomited bright blood and there was x-ray evidence suggestive of a duodenal ulcer. I explored him and opened his stomach and could not find a thing. He bled afterward and ultimately it was found he had a curious blood vascular condition in the lower two or three inches of his esophagus. I cite that to show how sound the statement of Dr. Edwards was, that in those cases where you do not find objective evidence of a lesion that can account for bleeding in the stomach itself, it is silly to do a gastrectomy.

Q. DR. STONE: I find there are many more questions here but it is getting too late and I don't want to protract this session unduly and kill whatever good effect it may have had by fatiguing you. There is just one more question that came up marked final. How often do peptic ulcers heal and stay healed? Dr. Howard, do you want to talk on that?

DR. HOWARD: I'm sure that peptic ulcers heal very often and that between relapses they remain healed. I'll admit that every once in a while one will see someone who has a crater demonstrated when he has no symptoms, but that is unusual. I believe the ulcer heals and then opens again some autumn or spring or when the patient goes on an alcoholic binge, or is under great strain. It is generally the same ulcer that opens up. Just a word about this presence of a crater in the absence of symptoms. I think it has been shown very definitely that banthine relieves the pain and yet the roentgenologists can still demonstrate the crater. But that crater will heal eventually. In most cases when a crater is demonstrated, the patient has symptoms and it may heal spontaneously or sometimes we may help it to heal. I think that we are of some use; we try to do good with our antacid therapy and with our measures for the reduction of gastric secretion.

DR. STONE: I just want to thank the members of the panel and to thank Dr. Fort and his committee for arranging the meeting.

The meeting is adjourned.

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MEDICAL AND CHIRURGICAL FACULTY RECENT APPOINTMENTS ON THE MARYLAND MEDICAL SERVICE, INC.

The Medical and Chirurgical Faculty has appointed the following Class "A" members of the Corporation, Maryland Medical Service, Inc.:

Dr. Warde B. Allan — Dr. Hugh J. Jewett
Dr. Robert P. Conrad — Dr. I. Ridgeway Trimble

Also in conformity with the By-Laws of the Maryland Medical Service, Inc., a panel of nine physicians to serve as a Reference and Appeals Committee, consisting of the following has been appointed:

Dr. Thurston R. Adams — Dr. John B. DeHoff
Dr. Lester T. Chance — Dr. Donald Hooker
Dr. E. T. Lisansky — Dr. E. Roderick Shipley
Dr. J. Mason Knox III — Dr. S. Edwin Muller
Dr. John W. Parsons

The last three named members serve on the Medical Relations Committee.

MEDICOLEGAL SYMPOSIUM—DRUG ADDICTION[1]

Continued from the January issue

JUDICIAL ADMINISTRATION OF VIOLATIONS

HONORABLE JOSEPH SHERBOW

Judge of the Supreme Bench of Baltimore City

MR. THEODORE C. WATERS: The people of the State of Maryland, particularly the City of Baltimore take pride in the industry, wisdom and individuality of the members of the Supreme Bench of Baltimore City. Since his appointment and election to that office, Judge Sherbow has conducted himself in a manner that emphasizes the majesty and dignity of the law. When presiding in the Criminal Courts, he is ruthless in his determination to enforce the laws and punish all criminals without fear or favor. He brings to his office an understanding of the frailties of nature with due regard and sympathy to those who are victims of the use of drugs. I know I do not have to tell you of the wonderful job that Judge Sherbow has done and he will now discuss the Rôle of the Courts in the Administration of the Law Applicable to this Subject.

JUDGE JOSEPH SHERBOW: Thank you, Mr. Waters. Ladies and Gentlemen, my rôle today, as I understand it, is to discuss the judicial administration of the law insofar as Dope Addiction is concerned. The Lawyers know, but the Doctors and perhaps the general public does not know, that Judges in Baltimore rotate; they don't remain in one Court more than one year. I had never been in Criminal Court Part I before January of this year. I look forward to January 1952 as the happiest day of my life. I want to get out of that Court in the worst way possible, and I'm not referring alone to the situation as it deals with gambling. I'm referring primarily to the situation as it deals with narcotics in this City.

I have never seen a parade as degrading, as terrible as the parade of the addicts and the peddlers that we have had this year, and I have never felt so completely frustrated as I do now in October 1951, after nearly ten months in that court.

Let me give you just a little bit of history, and it is very recent history. I came into that Court in January. I had had a few months of experience in helping to organize the Youth Court —and I hope you will forgive me if I use the personal pronoun—but to get my point across I must talk to you on the personal level. In the Youth Court I had had four gangster-style bandits who held up some Loan Companies at pistol point, one after the other and robbed them. They were arrested and convicted. We went into those cases thoroughly and we found dope at the bottom of them.

That opened my eyes because I wanted to know more about it and when I was assigned to Criminal Court Part I, I thought the first thing to do would be to find out from the experts. So I asked Mr. Boyd Martin of the Federal Narcotics Bureau to come over to see me, which he did, and to borrow a phrase from the streets "I almost fell off my chair" when I found he had only three Narcotic Investigators for the whole State of Maryland—three, and they weren't always available for Baltimore.

Then I asked the Commissioner of Police if he wouldn't stop in to see me and I was astounded to find out that we did not have a Police Narcotic Squad. It was everybody's business in the Police Department; it was also the business of the Plain Clothes Squads, but we had nobody who devoted himself specifically to Narcotics.

Just about that time Judge Niles in the Youth

[1] Presented on Saturday, October 13, 1951, Osler Hall, Medical and Chirurgical Faculty Building, under the auspices of the Medicolegal Committee of the Bar Association of Baltimore City and the Medical and Chirurgical Faculty.

Court had a series of boys under twenty-one, who were charged with gangster-style banditry at the point of a gun and he went into it thoroughly and came up with the same answer—DOPE. Just at that particular time we had a murder case and the answer to the murder case was—DOPE. And I began to demand action—to try to make the public see this menace. One day there was an awakening.

We had three white boys who came from nice, middle class families—no different, no worse than the boys I went to school with—and they were charged with selling Marihuana. The day of their trial in that courtroom there were about eighty of the most strangely dressed boys and girls I have ever seen in my life. When you looked at them a little more closely you found they weren't youths, but some of them were as much as forty years of age. They had on "young" overcoats, and suit-coats, not like those we are wearing, but way down to the knees. You couldn't see the kind of shoes they were wearing, but my bailiff told me they had suede shoes on. They had a peculiar kind of pants, and long sideburns with the hair down this way and cut like that (DEMONSTRATES). We had girls sitting in the courtroom, the kind you would expect if you were going on a slumming expedition to the "block" in Baltimore, sitting there in the courtroom.

Then we had to announce that those cases were going to be postponed until the afternoon because some other cases were going to take up the whole morning. They all got up and walked out and I asked the bailiffs to mingle with them in the corridor. I want to tell some of you hardened doctors that the kind of language dealing with sex that went on out in that corridor is what you wouldn't even be familiar with; it wasn't filthy, it was so degrading it was disgraceful; it was awful and they were talking and using that language out in the corridor between Criminal Court Part I and the Grand Jury Room in the same way we say "this meeting will adjourn at such and such o'clock."

In the middle of those cases, one of the boys pleaded guilty and Mr. Lannigan of the Federal Narcotics Bureau took the stand to explain something. The lawyer turned to him and said: "There isn't very much involved in the fact these kids are smoking Marihuana, is there?" And I never saw a man's Irish dander get up the way Mr. Lannigan's did. He turned to their lawyer and said: "You don't know how bad the situation really is" and then for five minutes he let him have it. He told what Marihuana does and how it leads into Heroin. When he was finished I said, "Mr. Lannigan you told it to the wrong man, now turn around and tell it to that audience, just look at them and tell them." For five minutes he told them what was really involved—and they listened. I think that's the beginning in Baltimore City of a public awareness of dope. It hit the papers hard because nobody would believe that kids of fifteen years of age were selling eighty to ninety cigarettes, Marihuana cigarettes at the Knights of Columbus Hall, Eastern Avenue and Conklin Street on Friday night and there were more than two or three kids doing the selling. And that was only one spot—one public dance hall, and there are plenty more.

If I had a map of the City of Baltimore here, I could pinpoint for you right now areas in this city where there are young people less than twenty-five years of age congregating, smoking Marihuana and getting Heroin and I'll tell you where they are. Park Heights and Belvedere; Liberty Heights and Garrison; in the Hampden Section, two; in East Baltimore, at least three; in Northeast Baltimore, at least three. If you come from Roland Park or Guilford, or Catonsville, don't brush it aside, we've got the kids coming from the better neighborhoods, too, who are involved and who are being treated by psychiatrists and psychologists. You can't name a section of Baltimore City where we don't have cases.

I have on my desk today a letter from one of the doctors in this community, begging me to

do something for the son of his very dear friend who has become a hopeless addict. There isn't anything I can do except hope he comes to Baltimore and we can have him arrested. Then I can act. However, as long as he stays a few miles out of Baltimore City there is nothing that will happen to him because there is little enforcement there; they won't even know how to recognize the situation.

Now, what are we doing about this situation? I want to add to what Dr. Dearborn said, and that is that in addition to the habituation the strangest kind of phenomena takes place where a Heroin addict is involved. If you ask me to take a drink and at the moment I say I don't want it you don't press it on me. If you suggest a cigar and I say I'm not smoking at the moment and I don't take it, you don't make me take it. But if you are a Heroin addict somehow or other you're convinced that you just *have* to make the other fellow become one also. They have an insatiable desire to make other people addicts.

Well, we faced the problem, but what did we do about it? First, let me say, we did have the most remarkable cooperation in law enforcement that I have ever seen and I limit it only to narcotics. We obtained from the City authorities, Mayor D'Alesandro and the Board of Estimates, Ten Thousand Dollars for Mr. Sodaro's office. A Narcotic Squad was formed. I cannot give you high enough praise for the Narcotics Squad; at the appropriate time I propose to do something about it. Those men just work around the clock. You just can't work on an eight-hour shift where Narcotics are involved. Sometimes I wonder when they sleep. They are doing a wonderful job. We have at the moment any number of peddlers in prison. We have a large number of addicts in the House of Correction and elsewhere. A very few are out on parole.

WHY DO I FEEL FRUSTRATED? I'll tell you. We aren't doing anything for those addicts. I say and I repeat, we aren't doing anything for them. Very few can be sent to Lexington, Kentucky. We do get a couple of them sent there. The Mayor and his Committee under Mr. Jett explored the situation insofar as Baltimore City is concerned with the idea of having some kind of a controlled clinic at the City Hospital. That meeting only took place the day before yesterday. We won't have any Control Clinics in the City and I don't think we should, because the City would be embarking on a program that would soon cost half a million dollars a year. It isn't the kind of a program that the City can handle by itself. Let me show you what it involves.

Under our system we have segregation and that means in a controlled clinic you have to divide the whites from the colored. Then you have to divide the male from the female and you haven't even begun to do your job because if you don't separate within that group by classification those who have a chance to be saved from those who are pretty much hopeless, you won't get anywhere. Now, after the withdrawal symptoms are past they walk around and there is nothing the matter with them except a craving for the drug which they would get the moment they got on the outside. You can't leave them in bed in a hospital. You have to find something for them to do, and more important than all of that, you have to give them psychiatric treatment. We don't have the personnel in this community for the job. The matter now is under consideration by Dr. Perkins and his group. The last word received from them was that perhaps by February they may be able to undertake some part of the job on the State level. I hope so but I doubt if we will have any beds for this problem by spring.

What do I do with the addicts when they are convicted? I send them to the House of Correction, I can't let them stay out on the streets. I do sometimes put a few good prospects on parole, but I get them back within a few months. In the House of Correction the Warden puts them out on the farm and they get along fine. Soon they want to get out and the minute they

get back to Baltimore, if the drugs are available, they'll get them. Even at the Lexington Hospital where they have the most intensive kind of treatment the percentage of success is not good. It's not Lexington's fault, it's the fact we haven't yet found an answer to the problem; we don't have any penicillin for drug addicts that will cure them.

What is the answer? Is it to impose harsher penalties? We now have laws requiring the imposition of heavier penalties. I'm going to ask the Legislative Council to amend the laws. The Legislature in passing the statutes has created some difficulty by making certain sentences mandatory. I see here in the audience today a distinguished, retired member of the Supreme Bench, Judge O'Dunne, who is responsible for one of the most important pieces of legislation we have ever had on our statute books. I refer to the O'Dunne Act which provides that no matter what the minimum sentence may be, *no* Judge is required to impose any minimum sentence. He can impose whatever in his judgment is proper provided he doesn't go beyond the maximum set by law. Judge O'Dunne in securing the passage of that statute gave to the Courts a weapon which we believe has been used most satisfactorily, but in connection with Narcotics the Legislature in passing this statute imposed certain mandatory requirements and it is not working well.

I have cases of drug addicts, whom I might be required under this statute to sentence to long, long years of imprisonment which would be wrong in their cases and tragic perhaps. If the O'Dunne Act were made applicable to that statute the Judge could impose whatever sentence was proper, provided it didn't go beyond the maximum. Whenever they read into a statute that a Judge must impose certain mandatory sentences they rob him of discretion and that means that two people who may have committed the same crime, one of whom can be rehabilitated and the other is a hopeless derelict must receive the same sentence. The importance of the severity of the sentence does not mean too much to the confirmed addict. When he wants the drug it doesn't make any difference what is involved, murder, or prostitution, he or she will get the drug. The importance of the severity of sentence is to the peddler. We must put the peddlers away. They are not addicts, like the "gophers," "the pushers," who are little fellows and usually addicts. It is important to have this power to impose severe sentences on peddlers—and to use it.

In Baltimore we have law enforcement clicking beautifully on every front in the attack on narcotics. Yet we are as wide open as the Washington Boulevard, the Pennsylvania and the B & O Railroads and the Bus Lines that go to Washington. I tell you that I have to control myself at times when I listen to what these addicts say—and they are not repeating it for my benefit because their statements were taken weeks before, sometimes months. "Where do you get it?" "Such and such a street in Washington," Washington, Washington, always Washington! I tell you— and here I use measured terms,—I'm a Judge and I'm supposed to be careful in the language I use,—but I say the fact that the City of Washington, the Capitol of the United States, is the major source of Heroin supply for the City of Baltimore is an outrage and a disgrace.

I haven't even gotten to first base insofar as that charge is concerned. I have said this before the Senate Committees, I said it to the Grand Jury in my charge to them. It is a fact and it is obvious from these cases. As of today if there is anything going on over in Washington to stamp dope out we haven't heard about it over in Baltimore. Don't blame it on the Federal people, they still have only two or three operatives for a large area. It's a local Police enforcement problem and if the police won't go into that problem in Washington and break it up it won't be broken.

The original source of opium is Iran, Iraq, and other countries of the Near East. It gets to Italy where it is processed into Heroin and smug-

gled into this country. You could take this jar here (DEMONSTRATES WATER PITCHER), and it would be worth a quarter million dollars in Heroin in the illegal market because by the time it gets to the addict it is cut down with milk sugar to such an extent that that much pure Heroin would be worth a fortune. The same way twelve and a half pounds of Marihuana recently found in Baltimore will make forty thousand cigarettes; forty thousand cigarettes is worth twenty thousand dollars in the retail market.

The United Nations is making some effort on the international level. Remember how kidnapping was stamped out? In stamping out kidnapping we got harsh laws with severe penalties, but they weren't worth anything until we caught the criminal. There was relentless, unremitting pursuit of the criminals and it was stamped out. Today the younger group that are here don't even know what I am talking about when I say kidnapping was once a constant fear and threat to people in public life and the tremendously wealthy. That isn't so today. The Federal Government and the State Government each has a job to do.

I want to say one thing more. I'm not following any prepared address, but I want to make this one additional statement,—if you think it can't happen to people that you know; if you think it can only happen to people in the lower economic groups, to slum inhabitants, take my word for it, you are wrong. We can give you cases of children going to grammar school who were smoking Marihuana, one eighth grade school child of fifteen, and high school girls smoking marihuana, boys, numbers of them, doing the same thing.

If you ask me is there marihuana *in* the schools, my answer is that when girls going to high school in my day got into trouble, the trouble didn't happen in the corridor of the high school, it happened outside of the high school but it began in connection with their friendships made in school. Mr. Thomsen will discuss that phase with you.

I want to tell you I was almost made ill two weeks ago when I had a parade before me in court of kids—for that is what they were—white and colored kids who were involved in this dreadful mess. They started to smoke marihuana in automobiles around Belvedere and Park Heights Avenue; they even had parties in the club cellars of their own homes. One girl is all of seventeen.

How could she have started it, do you want to know? And this is why there should be real fear: "We were all in a car together and one of the boys had it and you were 'chicken' if you didn't smoke it, well, I couldn't be 'chicken' so I took a few puffs." And then the other girl got these girls to go to a hotel, not a second-rate or a third-rate, but a tenth-rate dive with older people where they were "turned on" as the vernacular goes, into the use of Heroin.

Now, are these addicts? I don't know. All I know is that every statement—and I read them all last night because I have to sentence them on Monday—everything I read was marihuana, heroin, heroin, marihuana and there isn't, with the exception of the person involved in the original peddling, one of them that is over twenty-five years of age. The parents of the fifteen year old child got her out of the neighborhood; as to the seventeen year old child the father pulled up lock, stock and barrel and moved out of the city with his daughter, thinking he could save her that way.

This is a most serious problem. Here are some of the things we have to do. First, we have to catch the peddlers and impose the severest penalties the law will allow on those peddlers. The addicts have to be treated, whether it be at the House of Correction, the Reformatory or in the Penitentiary, but they have to be treated. We have to destroy the source of supply so that when they come out of prison they won't be able to get the drugs. You will never destroy it in a city like Baltimore as long as it is so easy to obtain it just thirty-eight miles away in the city of Washington. As late as yesterday morning I conferred with some of our officials and found

out that Baltimore City is so tight that even the addicts are going over to Washington two or three at a time and taking the stuff over there for fear that if they come to Baltimore with a cap—just one—the police are going to get them.

Now, there is the picture and it is pretty bad. Thank you.

CARE, TREATMENT AND REHABILITATION—NARCOTIC DRUG ADDICTS

JAMES V. LOWRY, M.D.

Community Services Branch, National Institute of Mental Health[1]

The World Health Organization has defined drug addiction as follows: "Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: 1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; 2) a tendency to increase the dose; 3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug." The care, treatment and rehabilitation of narcotic drug addicts is based upon consideration of the individual who uses drugs, the drugs the individual uses, and the environmental influences effecting the user.

Many persons have had narcotic drugs administered to them in the course of medical treatment of some illness. This, however, is rarely the initial step in addiction. Persons who become addicted usually are introduced to drugs by an addict. Those who continue to use drugs after the initial experience do so because drugs satisfy some need of the individual.

Some persons discover that drugs provide relief from anxiety, tension, fear, or fatigue. An illustration of this is provided by the following history: A male addict had a severe anxiety neurosis which was completely masked when he was using heroin. His distress during the withdrawal period was not remarkable, but during the period immediately thereafter, he became increasingly tense, anxious, irritable and depressed. Three weeks after his last dose of drugs, he developed an acute anxiety reaction and suicided by jumping from an upper floor of the hospital. Some emotionally immature individuals discover that drugs provide the excitement, pleasure, and thrill which they continually seek. In some the rapid intravenous injection of the opiates produces an ecstatic sensation in the genital and abdominal regions that may be spread throughout the body. It apparently approximates the pleasurable feelings of a prolonged or intense orgasm. It should be remembered, however, that sexual drive is diminished or absent when the individual is addicted to opiates, and in women, menstruation usually ceases. With some persons the use of drugs is a component of aggressive, hostile, antisocial behavior. Others find that drugs can be utilized as a substitute for behavior less tolerated by society than addiction. An illustration of this is the case of a homosexual physician. He found that his homosexual drives disappeared when he was using morphine, thus enabling him to continue to practice medicine. When he became a medical officer in the Armed Forces, he was unable to obtain sufficient quantities to satisfy his needs. He resumed his homosexual activities which eventually resulted in his discharge. Once again he became addicted to morphine and practiced medicine successfully until he was apprehended for violation of the narcotic laws.

When the needs of the individual, whatever

[1] National Institute of Health, U. S. Public Health Service, Bethesda, Maryland.

they may be, are satisfied by drugs, then that individual becomes emotionally dependent on drugs and is driven to their continued use. This condition is the cardinal characteristic of addiction—emotional dependence on drugs.

Many drugs are capable of producing addiction. Alcohol, of course, is the most widely used. Other sedatives of significance are the barbiturates, bromides and marihuana. The commonly used opiates are heroin and morphine. Of some importance are the synthetic analgesics Demerol and methadone. The only stimulants of significance with regard to addiction are cocaine and amphetamine. The continued use of any of these drugs results in emotional dependence upon them. Some—the opiates, the synthetic analgesics, and barbiturates cause physiological changes resulting in physical dependence. Once physical dependence has been established, drugs must be continued or the addict will suffer the agonies of withdrawal. To complicate the situation further, tolerance is developed for drugs that produce physical dependence. This means that to obtain the desired effect, the addict is required to take larger doses at shorter intervals. The opiates are almost always taken intravenously in order to obtain the maximum effect. The addict who uses opiates or synthetic analgesics is then driven by two compelling forces—the emotional dependence on drugs to satisfy his original needs and the dread of suffering if his physical dependence is not satisfied.

The treatment of narcotic addicts is impossible unless adequate facilities are available to keep the person in a drug-free environment. The difficulties of establishing such facilities in a general hospital are almost insurmountable. The desire to obtain the effect of drugs and to be relieved of the distress of withdrawal, prompts addicts to secure drugs by any manner possible. It is therefore imperative that rigid security precautions be taken so that narcotics are not available to addicts during treatment. On admission to a hospital the addict must be thoroughly examined to determine his physical status and to look for concealed narcotics. In obtaining the history, the kind and amount of drugs used should be ascertained if possible, but one must remember that information given by addicts may be quite inaccurate. The addict who is buying illegal drugs has no way of knowing how much of the product he buys is narcotic and how much is some other substance like lactose. Many addicts are inclined to exaggerate the quantity of drugs they have used believing that larger quantities of drugs will be administered to relieve distress and pain during the withdrawal period. Inquiry must be made to determine whether barbiturates are used in addition to opiates.

Without appropriate treatment, the signs of abstinence begin about 8 to 16 hours after the last dose of morphine. The intensity, duration and variety of symptoms is related to duration of addiction and the dosage of drug used. First, the patient becomes restless and somewhat somnolent for a period of three or four hours. This is followed by lacrimation, yawning, sweating and rhinorrhea. The symptoms become increasingly severe and after about 24 hours are accompanied by muscle cramps, retching, vomiting and diarrhea. There is a continual restless moving about, whether the patient is in or out of bed and bitter complaint of being cold. A severe weight loss may occur within the first 24 hours. Fever, elevated blood pressure, respiratory abnormalities commonly occur. The symptoms increase in intensity for about 36 to 48 hours, continue for approximately 24 hours, and then decline over the period of several days. The patient is left in a weak, restless, irritable state of fatigue. It then requires about four months to return to what might be called a normal physiological state. Minor physiological deviations may last as long as six months.

Physical dependence is produced by the opiates—morphine, heroin, dilaudid, etc. and by the synthetic analgesics Demerol and methadone. The general symptomatology of withdrawal is similar to that described for morphine, but intensity of symptoms varies from drug to drug

Withdrawal of heroin produces somewhat more severe symptoms and an earlier onset. The abstinence phenomena following withdrawal of methadone are mild in degree when compared with morphine. The onset is delayed and the duration is longer.

Prolonged use of large dosage of barbiturates produces physical dependence and the withdrawal phenomena may be severe. This has been demonstrated by Isbell,[2, 3, 4] et al. under experimental conditions. About 24 hours after the last dose of barbiturates, abdominal cramps and vomiting may occur and the patient becomes irritable, tense, and weak. Some time within the next several days grand mal convulsions may occur. The patient may develop a psychosis which is usually preceded by an inability to sleep for several days. The psychosis is characterized by auditory and visual hallucinations, disorientation for time and place, and delusions. The psychotic reaction may last for several days to a month.

The present management of the withdrawal of opiates and synthetic analgesics is based upon the substitution of methadone for the drug used. This is indicated by concomitant administration of the addicting drug and methadone in the first 24–48 hours. Administration of the addicting drug is then discontinued and methadone is given over a 10–14 day period. One milligram of methadone can be substituted for four milligrams of morphine or for two milligrams of heroin if the dosage of the addicting drug is known. During the withdrawal period barbiturates are given at night if required. If dehydration results from vomiting and diarrhea, infusions of saline and glucose are administered. Methadone prevents the occurrence of most abstinence signs and when methadone is no longer administered, the distress is mild.

[2] Isbell, Harris: Manifestations and Treatment of Addiction to Narcotic Drugs and Barbiturates. Med. Clinics of North America, **24:** No. 2, March 1950.

[3] Isbell H. et al.: Chronic Barbiturate Intoxication, and Experimental Study. Arch. Neur. and Psych., **64:** 1, July 1950.

[4] Isbell, Harris: Meeting a Growing Menace—Drug Addiction. The Herzk Report, July 1951.

Following the withdrawal period, four to six months are required for a return to normal physiological functioning. The patient's appetite increases and rapid weight gain occurs in the first thirty days. The patient becomes very optimistic with regard to his ability to live without drugs. Experience has shown that a discharge from the hospital at this time is almost invariably followed by a return to the use of drugs within a short period. Many addicts have physical defects which should be corrected, if possible. Those most commonly seen are respiratory and gastro-intestinal disorders. Some patients have illnesses requiring surgical intervention for the relief of pain. The discomfort of any illness will always remind the addict of the relief provided by narcotics and he may utilize any illness as a rationalization to return to the use of narcotics.

When the patient is no longer using narcotic drugs, the treatment is the same, regardless of the drug previously used. Treatment directed toward the primary problem—emotional dependence on narcotics. The treatment of the patient's physical dependence is a necessary preliminary phase. Treatment is then directed to the underlying factors that predispose the individual to the use of narcotic drugs. For those patients whose use of drugs is based upon a need to find relief from anxiety and discomfort of living, psychotherapy offers a chance of success. Following the withdrawal period, the treatment of the psychoneurotic addict differs in no way from the treatment of a psychoneurotic who has not used narcotic drugs. When the use of narcotics is a means of obtaining excitement and pleasure beyond that of normal social living, there will be less incentive to accept and participate in treatment. It is interesting to note that many of the emotionally immature pleasure-seeking individuals adjust themselves quite well to a rigidly controlled institutional environment. They find within themselves very little need to test the obvious limitations of the situation. They tend to conform with social patterns as long as they are under close surveillance. Such individuals should,

of course, be under supervision for a considerable period after they are released from the drug-free environment.

During the four to six months that the patient remains in the hospital following the withdrawal of narcotic drugs, there should be an effort to re-educate him to a reasonable manner of living. By the time an individual becomes addicted, his life has become so centered around the need for drugs and the ways to obtain them that he has become a practically useless social parasite. He has lost the respect of his family and his employers. He is no longer concerned with his appearance. He lives *in a world of fantasy* rather than reality when he has drugs; in a world of fear and panic when he is unable to obtain them. Having spent all of his available funds for drugs, he borrows, steals and begs from relatives and friends and may find it necessary to engage in thievery or other illicit activities to obtain money for drugs. One is thus presented with the problem, during the period of rehabilitation, of preparing this type of an individual for resumption of a useful, normal rôle in society. It is essential that the former addict be provided with regular work and be encouraged to live a more stable kind of existence by participating in responsibilities in the institution where he is being treated.

During the time the patient in the hospital is being prepared to return to a useful life in his community, attention must also be directed to the environment to which the patient will return. This requires an active social service program at the treatment institution so that the individual has some reasonable chance of obtaining employment, of being accepted by his family, and being given a fair chance by others when he returns to his community. Unless these conditions exist, the addict will be forced to seek out those people whom he remembers as his friends —drug addicts. Association with addicts is the most common method of relapse to the use of addicting drugs. Treated patients should be supervised for a period of approximately two years following their discharge from the hospital. It must always be remembered that the use of narcotic drugs represents a flight from reality. If he is frustrated or unhappy on his return to the community, he will remember with pleasure the freedom from worry produced by narcotic drugs. The possibility of this escape mechanism may grow in his mind until he can no longer resist it. There begins once again the cycle of initiation of addiction, growth in habit and dependence.

In the recent past considerable attention has been directed toward addiction in individuals under age 21. Addiction in this age group is not a new phenomena, since a study by Pescor[5] made 15 years ago of 1000 consecutive admissions to the Public Health Service Hospital, Lexington, Kentucky showed that 16 per cent had become addicted at 19 years or less, and 45 per cent were addicted by the age of 24. Research on the personality characteristics of younger addicts is now under way at the Lexington Hospital and a research grant has been made to support a study of the community aspects of addiction in this group. Until additional knowledge is obtained, the treatment of the younger addict will continue to be the same as for the older addict. Segregation of the younger addict from the older is probably advisable if it can be accomplished.

What are the results of treatment? Little information is available on the subject. At the Public Health Service Hospital in Lexington, an effort is made to follow the progress of the drug addicts for five years after their discharge. This, of course, is a difficult task. Many of the patients are voluntary patients, and follow-up is difficult if not impossible. Other patients are under the supervision of federal probation officers for a period, and because of this, information can be obtained. The hospital does receive reports on former non-voluntary patients who are arrested for narcotic law violation and this provides another method of follow-up. Realizing all the inadequacies of the available information, an

[5] Pescor, Michael J.: A Statistical Analysis of the Clinical Records of Hospitalized Drug Addicts. Supplement No. 143 to the Public Health Reports.

attempt is made to determine the addiction status each year for five years following the patient's discharge. Information obtained indicates that 15 per cent of the patients remained off drugs for five years. About half the patients cannot be found and whether or not these people are using drugs is still an unanswered question. The remainder of the patients, some 35 per cent, are known to have relapsed to the use of narcotic drugs. A number of these who relapse do so after periods of one, two, three or four years following discharge.

SUMMARY

The care, treatment and rehabilitation of narcotic drug addicts can, in general, be grouped into three phases: (1) the withdrawal of narcotic drugs; (2) the correction of physical defects and psychiatric care; and (3) rehabilitation and follow-up supervision.

THE PROBLEMS PRESENTED TO THE YOUTH OF THE COMMUNITY BY THE TRAFFIC IN DRUGS

ROSZEL C. THOMSEN, Esq.

Member of the Bar and President of the Baltimore City School Board

All four of the speakers you have just heard are what the sportswriters call "old pro's." They are experts on the subject under discussion. I am not even an experienced amateur. I have no competence to discuss the social aspects of the problem or to suggest legislative remedies; but I told Ted Waters that I would be glad to talk about what the schools in Baltimore are doing about the problem, what they can do, and what they should do.

1. WHAT THE SCHOOLS ARE DOING

Since 1938, most eighth-grade students have taken a course in hygiene, which includes a unit on narcotics. This unit was not especially designed to meet the current drug problems of young people, and is not effective for that purpose.

When the facts about the increased use of narcotics by young people appeared in the press last year, the senior high school principals met with Police Commissioner Ober and agreed upon procedures to follow in an effort to discover possible users of drugs and sources of supply. Teachers have referred to school nurses and doctors a considerable number of pupils who were suspected of using drugs, but I am told that no user has ever been discovered in this way. Some pupils have reported information about sellers, and we understand that some arrests have been made as a result of this information. It does not appear that any sales are being made on school property. We have been told authoritatively by the local Federal agents that no person still attending school has been picked up as an addict in Baltimore in the past 36 years. The agents have arrested boys and girls 15 and 16 years of age who should be attending school, but they had left school and become delinquents.

Dr. Lillian Davis, Director of Health Education, has met with city, state and national health officers familiar with this field, and has worked with a federal interagency commission studying the problem. The Federal Narcotics Division has followed a "hush-hush" policy, and has taken the position that furnishing information concerning narcotics (under the guise of "education"), even in properly developed school courses, would do more harm than good. The schools have naturally given great weight to that recommendation.

Dr. Lemmel served on, and other members of the Department of Education met with, the Mayor's Emergency Youth Commission. They concurred in a statement to the general effect that it appeared inadvisable to overemphasize the problem, or to develop special courses dealing with it for use in the schools.

Members of the Department of Education have recently previewed a film dealing with this subject. They have also secured information about other films dealing with narcotics. However, they have discovered no suitable film.

At the beginning of the present school year, Dr. Lemmel appointed a Special Committee, including Principals, Counselors, Teachers and Nurses, to consider and recommend what the schools can and should do. This committee has held two meetings thus far, and has been asked to report as soon as possible.

2. WHAT THE SCHOOLS CAN DO.

The schools can do a number of things: e.g., they can teach teachers, they can teach pupils, and they can teach parents, the importance of the problem.

They can teach all teachers, principals, counselors and nurses to be more alert and skillful in detecting users, and in helping those whom they discover. They can teach certain teachers to conduct suitable courses for pupils at junior high and senior high levels, and to present information to parents simply and effectively.

The schools can provide suitable courses for all junior high and senior high students if it is decided that such courses are advisable. Those courses, in certain schools at least, might include a study of the dangers of other drugs besides marihuana and heroin.

The schools can present information to parents through P.T.A. groups, parent education classes, and in special meetings, where each school would make a great effort to reach as many parents as possible.

3. WHAT THE SCHOOLS SHOULD DO

Is it advisable that the schools do all or any of these things? I do not want our staff committee to feel that I am trying to anticipate their recommendations, or to influence their deliberations. The School Board wants, and knows that it will be given their honest and informed opinion. It will probably have to pass on questions of policy involved in those recommendations. Any ideas now existent are subject to change upon further advice and instruction from experts.

Certain things appear obvious. Children are learning about narcotics from many sources: television, radio, newspapers and comic books. Much of this material is sensational, stimulates curiosity and presents only a part of the picture. Many groups which are studying the problem have come to the conclusion that the schools can and should teach young people about the dangers, the misery and the disgrace attendant upon the illegal use of drugs.

The Final Report of the Senate Crime Committee contained the following statement:

"*Education*—The committee does not subscribe to the theory that public discussion of drug addiction should be avoided to protect nonaddicts from being tempted to try drugs. As in the case of venereal diseases, the attack upon which has been greatly enhanced by public knowledge, the committee believes that *much will be gained by a carefully devised program of education* designed to make the people of the Nation aware of the true facts regarding the excessive use of narcotic drugs.

* * * *

The committee believes that education should start in the schools and social organizations of the country and should be carried from there to the home. The basic responsibility for such a program rests on the shoulders of the country's educational leaders who should carry it forward at the local level."

I understand that the Federal Bureau of Narcotics now feels that parent education on the subject might be desirable. I believe the schools should make an effort to have all parents attend at least one meeting, and to advise them what they should do when they suspect or know that their children are using drugs. Some people do not like the idea of calling on Federal Agents. I suggest, therefore, that some appropriate agency establish two or more medical centers or offices,

at least one of which should have a Negro staff, where parents can freely go for advice and help.

Now that I have approached the subject assigned to me by making one suggestion, let me make one more. The Federal Government should provide institutions for the rehabilitation of youthful addicts separate from those institutions used for older addicts. In the existing institutions there is constant talk among the inmates about the effects of various drugs and where they can be obtained. That is about the only subject the older and younger addicts have in common. An institution set up especially for youths can take advantage of their interest in sports and other normal youth activities. Until the Federal Government acts, the State or City should make special provisions for youthful addicts. I understand that the Federal Bureau of Narcotics has proposed that the City establish a controlled ward in the City Hospital for the treatment of young addicts, and that the matter is under consideration by appropriate City Departments. Difficult problems of segregation and custody are involved. We have a reasonable chance of curing the young addicts—if we can give them proper treatment before they have been using drugs for two or three years.

The critical problem is the youth problem—to prevent the use of drugs by young people from pyramiding to unmanageable proportions. As the Senate Committee said: "One of the great contributions that could be made to the welfare of the young people of today would be to bring home to them the cold fact that narcotic drugs are to be avoided like the plague." The schools can make a large part of that contribution.

QUESTION AND ANSWER PERIOD

MR. WATERS: I'm going to ask the participants in the panel to answer the question as promptly and concisely as they can. Our respective committees, from both associations, have submitted to the Chairman prepared questions to be directed to the panel. In addition to that I do hope and propose to allow a very limited time to the audience to direct any questions that they care to ask the panel. If I may so proceed, I'm going to turn the guns on our good friend Joe Sherbow because when counsel is in his Court it is not an unusual experience to have him direct not one question to counsel but several, and in the interest of saving time I'm going to ask him three questions that have had a mutual bearing upon the particular subject with which they deal.

Q. Judge, do you have any impression as to whether or not existing facilities are adequate for the care and treatment of addicts in the State of Maryland?

In your opinion should there be legislation to provide special facilities for this purpose and while you are speaking on those two questions, Sir, would you kindly comment upon what the schools should do to assist in the control of traffic of drugs among teen-age individuals?

JUDGE SHERBOW: Let me try to answer these rather quickly. With respect to facilities in the State of Maryland, the answer is we have none, actually *N O N E*. All we have is a House of Correction and a State Reformatory. We have no place to send anybody for treatment. We could send them perhaps to the City Hospital but, they have no facilities for them either. Our State Hospitals—I'm talking now of the Insane Asylums, do not have the facilities or the staff to treat them.

Ought there to be special legislation—if by special legislation you mean ought we to have budget allocation, the answer is yes. The physical facilities I think ought to be arranged by Dr. Perkins but he ought to have the money, and have it quickly. What I'd like to do would be to take some of these kids of nineteen through twenty-five whom I see before me, and instead of sending them to reformatory, I'd send them to

a State Hospital on condition that they remain there until the authorities are satisfied that they can be safely restored to the community. But I can't send them to a hospital in Maryland. I've got to send them either to prison or let them go completely free.

Can the schools do more? Yes, they can and should do more. I only want to take one minute on this subject and say this; I talked with all the school Superintendents of Maryland at private meetings; I talked with Dr. Lemmel and others in connection with the schools. We are coming away from the idea that Mr. Thomsen touched on, I mean the feeling—"don't let's talk about it." It was like sex education, you just learned it only certain ways, you didn't hear it from nice people. Well, I think now we are getting to the point where people are beginning to realize and the O'Conor Committee emphasized the fact that there ought to be real education by competent people on narcotics. Now I'll tell you a strange secret, the law of Maryland requires the schools, *requires the schools* to teach the evils of alcoholism and narcotic addiction. I didn't know it until Dr. Pullen called my attention to it, but that doesn't mean you want to teach it to third graders or eighth graders. What we ought to do to sum up what Mr. Thomsen says is to teach it at the Parent-Teachers Meetings, to the pupils in the upper grades of high schools, we ought to teach it to the *teachers* so they would know what we are talking about. We ought to make the people in the higher echelon in the school department know what we are talking about, because I'm not sure that they quite realize how terrifically serious this problem is.

Q. FROM AUDIENCE: This question is addressed to Judge Sherbow. The point I want to make is this. Why are you disturbed because the drug addicts are moving out among the better class of people? It seems to me it's a community problem.

JUDGE SHERBOW: The gentleman says he is just as much disturbed with the fact that addicts are moving out, that we ought to be as much disturbed about the fact they are moving into the better economic groups. I agree with him a hundred per cent. I don't think we should recognize any distinction at all whether they are white, colored, rich or poor or whether they come from one section of the city or the other. What I tried to emphasize was the fact that nobody cared much until it got to the point where it hit some people in the better economic groups. Then they began to wake up to the fact that this could happen here. That is the tragedy of it; there wasn't any real interest that I could see until it happened to get to the point where people in the better economic groups were finding that the disease didn't know the boundary of one artificial distinction from another. I agree one hundred per cent with what he says. It's a community problem and it's a terrible problem.

Q. FROM AUDIENCE: Should not the problem of law enforcement in the Counties, at least in the field of narcotics be handled on the State level, particularly since the personnel in some of the County Police Departments are appointed on the basis of political acumen rather than police accomplishment?

JUDGE SHERBOW: The question he asked would take some time to answer, I think this question indicates there is an awareness that there isn't good law enforcement in certain places. To come back to the question, the answer is no, you don't need enforcement on a State level. Who would know better, who should know better who is involved in narcotics and other law violations than the local police, if they are doing their jobs? It's true in all rural sections you don't have intense policing but people in rural areas have a way of letting the police know what is going on. Now, if you are going to delegate this kind of enforcement to the State you will get no enforcement at all. The task is peculiarly local; it was so in Baltimore. We deal with the Federal people by interchange of information; we deal with them by use of certain of their facilities but the job is done locally in Baltimore City by the local police. It could be done in any County by the

County Police. If you haven't got police who will enforce the law put them out and get police who will!

Q. What is the percentage of cure of addicts after treatment? Do you have any data or statistics with respect to that question?

DR. LOWRY: Patients are followed for five years after their discharge from the hospital at Lexington where they are treated for narcotic drug addiction. At the end of five years, it is impossible to obtain information on fifty per cent; thirty-five per cent have relapsed to the use of drugs, and fifteen per cent have not used drugs during the five-year period. Some of those who were counted in the relapse group may not be using drugs at the end of the five-year period but did use them at some time during the five years. Of those that relapse, a number go for one, two or three years before relapse occurs.

Q. What do you think the schools should do about addiction?

DR. LOWRY: My professional qualifications are in the medical treatment of narcotic drug addicts. My personal feeling is that too much public and parent responsibility is often shifted to the schools. This is not a school problem fundamentally, but is a problem of the family and society generally. The school can be looked upon as a medium to reach parents and children. Whether or not education regarding addiction will prevent addiction remains to be determined. Physicians are the best informed group about the addicting properties of drugs. The proportion of drug addicts among physicians is at least ten times that of the general population.

Q. What characteristic seems to be most strongly present in persons predisposed to drug addiction?

DR. LOWRY: There is no single characteristic. In my presentation, I enumerated several types of individuals; 1) the anxious, neurotic, tense individual who is seeking relief from his discomfort; 2) the emotionally immature unstable persons who aren't satisfied with the normal satisfactions of living but who are seeking thrills, pleasure and excitement; 3) the group of predominately anti-social aggressive individuals whose use of drugs is just one facet in the total configuration. All three groups are attempting to escape reality.

Q. MR. WATERS: This is an interesting question that may lead to a difference of opinion between our learned Judge and our Prosecuting Attorney—that is not unusual. I'd like to ask Mr. Sodaro if experience has indicated that the traffic in drugs in Baltimore City is limited to a relatively small group or general throughout the community, and in answering that, Mr. Sodaro, I think it would be of interest to the audience if you would comment upon the personalities and the type of people with whom you have to deal in this particular problem?

MR. SODARO: Well, it has been generally found that the average type of individual whether a juvenile or not, that comes into Criminal Court charged with violation of the Narcotics Law, is the delinquent type of person. Now that doesn't mean that there aren't exceptions. Judge Sherbow a little while ago gave you an example where it can happen in the nicer type of homes. There is always a danger that the disease may infiltrate into the nicer neighborhood and nicer homes. We have had many instances where defendants have come into Court from broken homes. A broken home is always a real source of trouble not only for narcotics but everv other type of crime.

THE DIAGNOSIS OF CHRONIC VIRAL HEPATITIS[1]

VICTOR M. SBOROV, M.D.[2]

In the past several years we have become more and more aware of the disease we have now learned to call acute viral hepatitis. During the years of World War II and in the postwar period this condition has been recognized as one of prime importance to the Military. Although percentagewise the mortality rate from this condition is not high, the prolonged period of hospitalization required in the management of the average case is of serious consequence to the Armed Forces. Physicians in civilian practice also have learned that the diagnosis of hepatitis must be considered in all patients with jaundice and in many patients without jaundice regardless of age, race or sex (1).

Because of its widespread incidence and its economic importance, acute hepatitis has been thoroughly studied by many groups over a period of years. The clinical manifestations and biochemical measurements of the disease have received a great deal of attention; and the usual characteristics of hepatitis have been repeatedly confirmed in many series covering large numbers of cases. We have learned, in general, that the disease may be a benign one, particularly in the younger age groups and that it is self-limited in most cases even without strict management.

In the usual course of events it has been found that the disease may be unusually prolonged by increased physical activity in the early stages (2). The period of jaundice and disability varies from a few days to several months, during which time the patient must be more or less restricted in his activities. An occasional case will have a fulminant course and expire in a period of hours to days. In epidemics involving large numbers of individuals we have learned that there will be one to two deaths per thousand cases of hepatitis (3). An occasional patient, even though well treated, will have a relapse from his hepatitis which may prolong his period of hospitalization and convalescence by two to three months. This is not common, however, and is rarely encountered in the average practice of medicine. Such an unfortunate event may be inadvertently brought about by the physician who wrongly diagnoses a case of viral hepatitis as one of surgical jaundice and superimposes the trauma of surgery and anesthesia upon an already damaged liver. It is of the utmost importance, therefore, that viral hepatitis be diagnosed early so that harmful maneuvers, such as major surgical procedures may be scrupulously avoided.

It has been suspected for many years that chronic liver disease might result in a certain number of cases with a past history of acute viral hepatitis. The exact incidence of this complication of acute hepatitis is not known, but there seems to be little doubt that chronic liver disease results in a definite number of patients as a sequel to acute hepatitis (4, 5). If one were to follow a known group of patients with acute viral hepatitis, over a period of six to ten years, one might not be impressed with the number of patients who would develop chronic liver disease. A few such studies have been undertaken and it has been found that after a period of five years such cases number less than one per cent of the total. If, on the other hand, one were to see a large number of cases of chronic liver disease one would be distinctly impressed with the number of such cases that appeared to stem from a previous bout of acute viral hepatitis. Thus, in the course of study of acute viral hepatitis, there has been recognized a group of cases with persistent or intermittent symptoms and findings lasting for months or years after a bout of acute hepatitis. The course of such patients is variable; some apparently go on to complete recovery while others manifest a chronic downhill course, ultimately resulting in death. It is, therefore, of some importance in our understanding of liver

[1] Presented before the Annual Meeting of the Baltimore City Medical Society on Friday, December 21, 1951.

[2] From the Department of Hepatic and Metabolic Diseases, Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington 12, D. C.

disease to ask ourselves, "what is chronic viral hepatitis?"

If one did not clearly define the term "chronic viral hepatitis" there would be many abuses of this diagnosis. This is true since many of the symptoms present in such patients are admittedly identical with those found in functional gastrointestinal disease. Due to the lack of a specific test for the disease an exact definition of this condition is not possible at the present time. A practical definition to be used as a guide in diagnosis and management should include the following: No patient should be said to have chronic viral hepatitis unless there is a history of acute viral hepatitis. There should be symptoms, physical findings or laboratory findings of hepatic disease which persist or recur six months or longer after a bout of acute hepatitis; and a biopsy of the liver should show abnormal liver histology (6). Although this definition may exclude a hypothetical group of patients with functional liver cell disease, it only includes those patients who have objective evidence of liver involvement which follow chronologically a bout of acute viral hepatitis.

TABLE I

Symptoms and Findings in 48 Cases of Chronic Viral Hepatitis

	PER CENT
Hepatic Enlargement	58
R. U. Q. Ache	41
Easy Fatigability	41
Hepatic Tenderness	37
Spider Angiomata	31
Intermittent Nausea	29
Epigastric Distress	27
Nervousness	22
Intermittent Malaise	14
Intermittent Diarrhea	14
Palmar Erythema	14
Fatty Food Dyscrasia	10
Palpable Spleen	10

In the past three years we have had the opportunity to study carefully 48 patients who meet these criteria. In the reconstruction of the chronology of this disease, we have found that the manifestations usually appear in one of two ways. In the early course of his illness the patient may appear to show a satisfactory recovery manifested by a return to well being and a diminution in the positivity of his liver function tests. In the later course of convalescence, however, recovery is not complete and certain symptoms and findings pointing to hepatic dysfunction persist for a period of months to years. The patient may remain easily fatigued; he may have recurrent gastrointestinal symptoms of nausea and anorexia; he may have a persistently or intermittently abnormal serum bilirubin test, bromsulfalein test, or other tests of abnormal hepatic function. On physical examination there may be found a large liver which is tender to palpation (Tables I and II).

TABLE II

Relative Frequency of Positive Liver Function Tests in 48 Cases of Chronic Viral Hepatitis

	PER CENT
Urine Urobilinogen	77
Bromsulfalein	73
Zinc Turbidity	68
Thymol Turbidity	38
Total Serum Bilirubin	29
Thymol Flocculation	27
One Minute Serum Bilirubin	23
Cephalin Cholesterol Flocculation	15
Urine Bilirubin	6

The second group, which corresponds to so-called "latent hepatitis" appears not to differ in any way whatever from the patient with the usual course of acute viral hepatitis. That is, after the first week or two of symptoms there is a definite and progressive return of well being with diminution to normal of liver function tests, and disappearance of the large tender liver. The total duration of the course usually does not exceed three months. After a varying period of months or years following return to full activity, however, the patient may begin again to notice the gradual onset of symptoms related to his liver. These symptoms may consist of easy fatigability and soreness in the right upper quadrant. Upon examination of such a patient there

may be found an enlarged tender liver with liver functional abnormalities as demonstrated in the laboratory.

Because chronic viral hepatitis has not been uniformly recognized as an entity, many such cases are misdiagnosed as psychoneurosis or as functional gastrointestinal diseases. With ordinary examination these patients frequently fail to show objective evidences of hepatic disease and it becomes difficult to relate symptoms they may have, to a previous bout of acute viral hepatitis which may have occurred months or even years in the past. In an average practice of medicine, where not many cases of acute viral hepatitis are seen, this chronic manifestation of acute liver disease may never be encountered. It is in fact, because the total mortality rate and total residual rate has been so low, that the average physician seldom sees either and considers hepatitis to be a completely benign disease unworthy of strict management. This is, however, not the case. It is important to be aware of the possibility of chronic liver disease, not only in the patient who manifests the symptoms and findings, but also in the early treatment of viral hepatitis so that proper precautions can be taken to ensure a minimum period of disability.

Such reports as are available of chronic liver disease following acute viral hepatitis have been gained from the Armed Forces where large numbers of cases of the acute disease have been seen. In 1944, a group of studies was reported by Caravati who referred to this picture as "the post-hepatitis syndrome" (7). The outstanding characteristics present in these patients were fatigue, right upper quadrant discomfort, fatty food intolerance, malnutrition and emotional instability. This picture was seen to last for weeks or months after the onset of acute viral hepatitis. Caravati recognized the relationship of this syndrome to acute hepatitis, but believed it was not related to organic liver disease. All of his patients had normal liver function tests and negative physical findings. Histologic studies were not made in these patients.

In 1946, Sherlock and Walshe reported another group of the so-called "post-hepatitis syndrome" among English soldiers (8). Here again, the manifestations were considered to be psychoneurotic in origin and not related to organic liver disease. In these patients there were also noted structural abnormalities of the liver upon biopsy and some borderline liver function tests. It was believed by the authors that the main motivation in these patients as far as their complaints were concerned was to be discharged from the Army. It was thought that patients of this type who were hospitalized as a group on a single ward exchanged complaints so that a similarity in wording of histories often was noted. All were anxious to display evidences of their hepatic disease. Many of this group were noted to have a palpable liver and spleen, but this was discounted somewhat by the authors who felt these patients were able to push down their livers and spleens merely by deep respiration rendering these organs palpable. Accordingly, the recommendation was made that such patients be dispersed about the hospital and not be allowed to compare symptoms so far as their liver disease was concerned.

Subsequent reports by several investigators in this country and abroad with the use of more refined liver function tests, and with the wider use of the liver biopsy, have confirmed the fact that the residuals of viral hepatitis previously described in patients at varying periods of time following acute hepatitis, are probably related to residual organic liver disease (9, 10). It is believed that most of these symptoms are not psychoneurotic. Although there may be a neurotic overlay in many of these patients because of the prolonged hospitalization, or because of the underlying personality defects, these may be true manifestations of chronic liver disease.

In considering the criteria for diagnosis of chronic viral hepatitis an unequivocal history of acute hepatitis should be obtained; this is necessary because the other enumerated criteria may

be present due to other forms of chronic liver disease unrelated to the virus of hepatitis. It is also believed that this history of acute hepatitis should include jaundice. There is little question that hepatitis may occur with subclinical or absent jaundice and that this condition may go on to a chronic form of the disease. A retrospective diagnosis of acute hepatitis without jaundice, however, would be difficult, if not impossible, to establish. If, on the other hand, a patient were observed by the same physician over a period of time, during which there was a transition from acute hepatitis to the chronic state, I believe it would be possible to establish the diagnosis of chronic hepatitis even without antecedent jaundice by means of other liver function tests and possibly by means of a liver biopsy. In the absence of this close observation and complete diagnostic study, however, the diagnosis cannot be proven.

Under ordinary circumstances the symptoms, clinical findings and laboratory findings of hepatic disease, which persist or recur six months or longer after the bout of acute hepatitis, are really the only signs we have of the persistence of the disease. Unless the course of the illness is followed from its very inception, it is not likely that laboratory tests will be performed in a routine fashion throughout the entire course. If symptoms persist however, the syndrome is

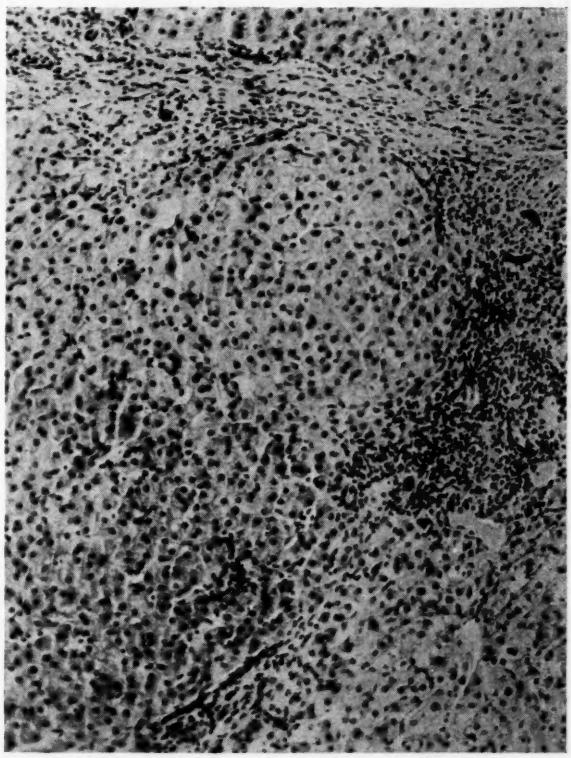

FIG. 1. Chronic viral hepatitis. Forty-four year old patient who first developed hepatitis eight years prior to present biopsy. Three recurrences with jaundice since. Symptoms of intermittent fatigue and epigastric distress. All liver function tests negative except for bromsulfalein retention of 15%. Section shows widening of portal space and increase of mononuclear infiltrate. Portal scarring is present with extension into the surrounding parenchyma. Increase in the number of bile ducts is seen. Foci of necrosis are noted in liver lobules. Liver cells show many binucleate forms. × 110.

called to the attention of the physician, who then carries out a physical examination and certain laboratory tests to establish a diagnosis. Even in the presence of objective findings in the clinical and laboratory examinations, it is believed that a liver biopsy is mandatory to establish the diagnosis of "chronic viral hepatitis" and to determine the stage of the disease. We have as yet not encountered a patient with positive liver function tests, with or without symptoms of chronic liver disease, who did not have abnormalities as demonstrated from a biopsy of the liver. The converse is not true, that is, *normal liver function tests may not mean a normal liver.*

The pathology encountered in the livers of patients with chronic viral hepatitis is widely variable (6). There may be only minimal changes consisting of binucleation of the liver cells and evidences of regeneration with small foci of mononuclear cells indicating necrosis. Bile duct proliferation is usually prominent and there are varying degrees of portal scarring present (Fig. 1). It is believed that without the other criteria for the diagnosis of chronic viral hepatitis the distinction of this condition cannot be made from the liver biopsy alone. Since the histologic findings noted in such patients are not discriminatory as far as other forms of liver disease are concerned, it is recognized that the diagnosis "chronic viral hepatitis" is *etiological* and may by definition include all phases of morphologic changes in the liver from "mild inflammatory changes" to "advanced scarring." Thus, what we now call cirrhosis of the liver could be included as an end stage of chronic viral hepatitis.

A great deal yet remains to be learned about this chronic phase of viral hepatitis. We are not at all confident that the predisposing factors for the development of chronic viral hepatitis are limited to those already enumerated, namely: older age at onset, use of alcohol, intercurrent infections, and incomplete therapy at the outset. It seems highly likely at the moment, though not yet proven, that there may be continued viral activity in these cases responsible for their clinical, biochemical, and histological manifestations of disease. Experiments are now in progress where the sera from patients with chronic viral hepatitis are injected into human volunteers to determine if the infectious agent remains active in these cases.

We are as yet in the very early stages of our study of this phase of liver disease. This report merely is intended to define the entity of chronic viral hepatitis so that in the future the discussion of this problem can proceed from a common starting point. Until there is uniform agreement concerning the existence of this stage of hepatitis and the criteria for its diagnosis, we cannot proceed with the important problems of pathogenesis, treatment and ultimate prognosis of this disease.

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Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.,
Journal Representative

On December 7, 1951, the following officers were elected: *President*, Emmett L. Jones, Jr.; *Vice-President*, W. R. Hodges, Jr.; *Secretary*, R. Rhett Rathbone; *Treasurer*, Leland B. Ranson; *Delegates*, John K. Rozum; James T. Johnson, Jr.; *Alternate Delegates*, Hilda Jane Walters; Bendeict Skitarelic.

The Allegany-Garrett County Medical Society has extended an invitation to the Medical and Chirurgical Faculty to hold its Semi-annual Meeting in Cumberland in 1953. Clinics would be held in the local hospitals by representatives from the University of Maryland Hospital and The Johns Hopkins Hospital.

The Council and House of Delegates of the Medical and Chirurgical Faculty will be informed by the Secretary of this invitation.

Dr. Edward Leach, of Baltimore, discussed "Heart Diseases in Pregnancy," at a meeting of the Society, which was held January 18, at the Cumberland Country Club.

In February, Dr. Edgar W. Davis, of Washington, D. C., will discuss "Newer Developments in Chest Surgery," with particular emphasis on earlier diagnosis.

Dr. C. C. Zimmermann, Cumberland, has just returned from the Bahamas.

Dr. James E. McLean assumed his new position as County Physician, January 1, succeeding Dr. Arthur Jones, also of Cumberland. Dr. Jones has returned to general practice.

Dr. Emmett L. Jones attended the General Meeting of the Pan American Association of Ophthalmology in Mexico City in early January.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.,
Journal Representative

At a recent meeting of the Anne Arundel County Medical Society, the following new members were elected: J. Howard Beard, A. R. Sosnowski, G. Douglas Trettin, M. K. Willoughby.

Dr. William N. Thomas was recently made head of the X-ray Department of the Anne Arundel General Hospital. Dr. Thomas comes to Annapolis well qualified. He completed a Fellowship with the Radiological Clinic of Doctors Groover, Christie, and Mearitt in Washington, D. C., and also served a year each in the X-ray Departments of Emergency, Doctors, and Garfield Hospitals in Washington. In December, 1950, he was certified by the American Board of Radiology.

BALTIMORE CITY MEDICAL SOCIETY

SAMUEL McLANAHAN, M.D., *President*

The new officers look forward to 1952, as a year of further expansion of the activities of the Society, and as a year in which an increasing number of individuals will be called upon to participate in the various opportunities and responsibilities which the organization presents. The thanks and appreciation of the Society go especially to Dr. Lewis P. Gundry, the retiring secretary who has served us so well for the past five years. The total membership of the Baltimore City Medical Society now stands at approximately 1,425. From this large number, the various committees have been appointed, totaling approximately 85 members. These committees are, of course, distinct from the committees of the Faculty, and these members are in addition to those already elected to serve as delegates to the State Society.

The Program Committee under the chairmanship of Dr. Wetherbee Fort is continuing its fine work of last year, with further excellent clinical sessions being planned for this spring and next fall. The programs this fall and winter have been well attended and have drawn praise from all quarters. Plans are already under way to make the facilities of Osler Hall more comfortable as well as more efficient. Financed jointly by the Faculty and by this Society a ventilating system will be installed and a new public address system with wire recorder, a new projector and a new screen will be placed in the Hall. The wire recorder will make it possible to preserve the addresses

and discussions for subsequent publication in this JOURNAL.

Members can be of real help by encouraging membership on the part of all eligible physicians in the community who are not already enrolled, by attending meetings of the Society and its special Sections and by giving constructive suggestions to the officers of the Society toward any means by which its service to the profession and to the community can be improved.

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall

SAMUEL MCLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*

J. ALBERT CHATARD, M.D., *Treasurer*

Friday, March 21, 1952, 8:30 p.m.

SYMPOSIUM ON THE DIAGNOSTIC PROBLEMS ASSOCIATED WITH FLUID AND ELECTROLYTE IMBALANCE

8:30 p.m.

Electrolyte and Fluid Problems in Surgical Patients. DAVID M. HUME, M.D., Junior Assistant in Surgery, Peter Bent Brigham Hospital; Instructor in Surgery and Director of Surgical Research, Harvard Medical School, Boston, Massachusetts. (By invitation.)

9:15 p.m.

Electrolyte Disturbances in Congestive Heart Failure. WILLIAM B. SCHWARTZ, JR., M.D., Assistant Professor of Medicine, Tufts College Medical School; Assistant Physician, New England Center Hospital, Boston, Massachusetts. (By invitation.)

10:00 p.m.

Question period.

ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D., *Chairman* EDWARD I. LEDERMAN, M.D., *Secretary*

Monday, March 3, 1952, 8:30 p.m.

Fire and Explosion Hazards in Hospitals and Their Prevention. Demonstration Lecture. (Lantern slides.) GEORGE J. THOMAS, M.D., Associate Professor of Surgical Anesthesiology and Chairman of the Section on Anesthesiology, University of Pittsburgh School of Medicine. (By invitation.)

SECTION ON DISEASES OF THE CHEST

MOSES S. SHILING, M.D., *Chairman* EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, March 5, 1952, 8:00 p.m.

A Study of Accuracy of Chest Film Interpretation. (Illustrated.) DAVID M. GOULD, M.D.

OPHTHALMOLOGICAL SECTION

ABRAHAM KREMEN, M.D., *Chairman* ANGUS L. MACLEAN, M.D., *Secretary*

JOINT MEETING WITH THE OPHTHALMOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

Thursday, March 6, 1952
Dinner 6:30 p.m., Scientific Meeting 8:00 p.m.
Stafford Hotel

Sensitization and Desensitization. RONALD M. WOOD, B.Sc., Mellon Fellow in Ophthalmology, The Johns Hopkins University School of Medicine. (By invitation.)

Management of Retinal Detachment. CHARLES L. SCHEPENS, M.D., Boston, Massachusetts. (By invitation.)

ORTHOPAEDIC SECTION

JESSE N. BORDEN, M.D., *Chairman* EDMOND J. MCDONNELL, M.D., *Secretary*

JOINT MEETING WITH THE ORTHOPAEDIC SECTION OF THE PHILADELPHIA MEDICAL SOCIETY

Friday, March 7, 1952
Scientific Meeting 3:00 p.m., Dinner 5:30 p.m.
Stafford Hotel, Baltimore

1. Central Dislocations of the Hip. GEORGE O. EATON, M.D.
2. Congenital Anomalies of the Spine. JAMES P. MILLER, M.D.
3. Developmental Aspects of the Spine. W. RICHARD FERGUSON, M.D.
4. Discograms and Diagnosis of Herniated Discs. JOHN J. DAVIES, M.D.

OTOLARYNGOLOGICAL SECTION

THOMAS R. O'ROURK, M.D., *Chairman* J. JULIAN CHISOLM, M.D., *Secretary*

Tuesday, March 11, 1952
Dinner Meeting, 6:30 p.m., Johns Hopkins Club, Homewood

Kodachrome Clinic of the Pathology of Bronchial Obstruction. PAUL H. HOLINGER, M.D., Associate Professor of Otolaryngology, University of Illinois School of Medicine, Chicago, Illinois. (By invitation.)

PEDIATRIC SECTION

WILSON GRUBB, M.D., *Chairman* GIBSON J. WELLS, M.D., *Secretary*

Tuesday, March 11, 1952, 8:30 p.m

Program to be announced.

NEUROPSYCHIATRIC SECTION

SAMUEL NOVEY, M.D., *Chairman*

Thursday, March 13, 1952, 8:30 p.m.

Cultural Anthropology. (*Title to be announced.*) DAVID ABERLE, Ph.D., The Johns Hopkins University.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Chairman*

Tuesday, March 11, 1952, 7:30 p.m.

Mercy Hospital

Program to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, March 20, 1952
5:00 to 6:00 p.m.

DERMATOLOGICAL SECTION

ISRAEL ZELIGMAN, M.D., *Chairman* RAYMOND C. V. ROBINSON, M.D., *Secretary*

Monday, March 24, 1952, 8:30 p.m.

1. Treatment of Superficial Angiomas. GRANT E. WARD, M.D.
   Discussion opened by FRANCIS A. ELLIS, M.D.
2. Chloromycetin in the Treatment of Dermatoses. (Illustrated.) HARRY M. ROBINSON, JR., M.D.
   Discussion opened by ROBERT T. PARKER, M.D.

MATERNAL MORTALITY MEETING

Thursday, March 27, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

RADIOLOGICAL SECTION

J. HOWARD FRANZ, M.D., *Chairman* RICHARD B. HANCHETT, M.D., *Secretary*

Due to the meeting of the Eastern Conference of Radiology, March 28 and 29, 1952, at the Hotel Statler, New York City, the regular March meeting of the Radiological Section will not be held.

SYMPOSIUM ON MEDICAL ASPECTS RELATING TO EUTHANASIA

Under the Auspices of the Medicolegal Committee

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, March 28, 1952, 8:00 p.m.

PANEL DISCUSSION

MR. JOHN S. STANLEY, *Moderator*

President, Maryland State Bar Association

1. Historical Development of Euthanasia. GEORGE BOAS, Ph.D., LL.D., Professor of the History of Philosophy, The Johns Hopkins University.
2. Legal Aspects Relating to Euthanasia. CHARLES E. ORTH, Esq., Formerly Assistant State's Attorney of Baltimore City.
3. Medical Aspects Relating to Euthanasia. LOUIS KRAUSE, M.D., Professor of Clinical Medicine, University of Maryland School of Medicine.

Questions from the floor.

CALVERT COUNTY MEDICAL SOCIETY

PAGE C. JETT, M.D.,
Journal Representative

At a meeting of the Calvert County Medical Society held January 8th, the following officers were elected for 1952: *President*, Roberto de Villarreal; *President-Elect*, Earl S. Coster; *Secretary-Treasurer*, Page C. Jett; *Delegate*, Hugh W. Ward; *Alternate Delegate*, George J. Weems.

The physicians in Calvert County are looking forward to the completion of the new $667,000 twenty-seven bed hospital which is being built on a site about a mile north of Prince Frederick. There has been a great need for adequate hospital facilities, and the Hill-Burton Fund with rural participation is making it possible to achieve this end.

The doctors are also looking forward to a reorganization of the staff so that better consultation services can be provided for this community.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT WRIGHT, M.D.,
Journal Representative

The following officers of the Caroline County Medical Society have been elected for 1952: *President*, James F. Wright; *Vice-President*, Charles H. Winnacott; *Secretary-Treasurer and Journal Representative*, Robert Wright; *Delegate*, Harold B. Plummer; *Alternate*, F. M. Anderson.

CARROLL COUNTY MEDICAL SOCIETY

M. C. PORTERFIELD, M.D.,
Journal Representative

On December 19, 1951, the Carroll County Medical Society elected the following officers: *President*, W. C. Jennette; *Vice-President*, Merritt Robertson; *Secretary-Treasurer*, Wilbur H. Foard; *Delegate*, M.

C. Porterfield; *Alternate Delegate*, R. E. Gardner, *Board of Censors*, R. S. McVaugh, Merritt Robertson, and James T. Marsh; *Medical Aid Advisory Committee*, Julius Chepko, M. C. Porterfield, and R. S. McVaugh.

On February 20, 1952, a meeting was held at the Hoffman Inn, Westminster. Dr. Paul Harper, Professor of Public Health Administration (Maternal and Child Health), The Johns Hopkins School of Hygiene and Public Health, will discuss a new statewide study on premature infants.

The construction of the new Carroll County War Memorial Medical Center is about half completed. It is located on the outskirts of Westminster. The new center is to serve as quarters for the County Health Department and will also provide space for various clinics.

NEW HEALTH OFFICER ASSUMES DUTIES

Dr. Neil Scott Gordon has been appointed Deputy State Health Officer of Carroll County, effective January 1, 1952. He is now directing the health program in this county.

Dr. Gordon, who is a Canadian, received the degree of Doctor of Medicine from Queen's University, Kingston, in 1940. He received a Diploma in Public Health from the University of Toronto in 1949.

The newly appointed health officer has had considerable hospital and public health experience, in addition to having served as a medical officer in the Royal Canadian Air Force during World War II. His most recent position was that of full-time District Medical Officer in the City of Toronto Department of Health.

DORCHESTER COUNTY MEDICAL SOCIETY

WALTER B. JOHNSON, M.D.,
Journal Representative

At the December meeting of the Dorchester County Medical Society, the following officers were elected for 1952: *President*, Alfred R. Maryanov; *Vice-President*, William H. Hanks; *Secretary-Treasurer*, Walter B. Johnson; *Delegate*, Eldridge H. Wolff; *Alternate Delegate*, John Mace, Jr.; *Board of Censors*, Lawrence Maryanov.

The Dorchester County Medical Society meets on the third Wednesday of each month. Prior to the Fall of 1950, meetings had been held in the Health Department office or the recreation room of the Cambridge-Hospital Nurses' Home. Monthly meetings are now being held at the homes of the various members, and following scientific and business sessions, refreshments are served. The attendance since this latter plan has been adopted, has increased from a former average of 25 or 30 per cent to an average of 80 or 90 per cent for each meeting.

During the past year, we have had five speakers from Baltimore, and have shown two films on medical topics.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D., *Secretary*

At a recent meeting of the Frederick County Medical Society, the following officers were elected for 1952: *President*, Charles H. Conley, Jr., *First Vice-President*, James E. Stoner, Jr.; *Second Vice-President*, B. O. Thomas, Jr.; *Treasurer*, John McC. Culler; *Secretary*, Jesse S. Fifer; *Delegate*, Jacob Elmer Harp; *Alternate Delegate*, Norvell Belt.

A unique organization has sprung up in Frederick County which is believed to be entirely original and which will serve many good purposes in the community.

In early spring, 1951, the idea of Hospital Aid, Inc., was conceived, nurtured, firmly established and then incorporated by civic minded professional, industrial, agricultural and commercial representatives.

Approximately sixty of these public spirited citizens became the directorate of this nonprofit organization, adopting the following objectives: The aim of Hospital Aid, Inc., is to help directly those confronted with illness or accident which necessitates hospitalization when insufficient funds are available to meet unexpected hospital bills, Hospital Aid, Inc., after proper investigation of requests for assistance, will pay the hospital bill. The loan can be repaid without interest, at a rate convenient for the borrower, as little as a dollar a week.

How are funds obtained and used? Hospital Aid's sole source of income is dues collected from its voluntary membership. As loans are repaid, the money goes back to the fund to be loaned out again. To

date, approximately four hundred twenty persons have joined Hospital Aid by paying yearly dues in one of the following amounts: $6.00, $12.00, $25.00, $50.00, $100.00, or by obtaining a life membership for $1,000.00. All are eligible for membership. Membership may be obtained by selecting the type of dues desired and mailing the amount to Hospital Aid, Inc. P.O.Box # 111, Frederick, Maryland.

In addition to helping those who temporarily can't help themselves, Hospital Aid may financially assist the Frederick Memorial Hospital. This hospital is looked upon as the natural hospitalization center for Frederick and adjacent counties.

In commenting upon Hospital Aid, Inc., one of its directors said: "The numerous letters we have received from people in all walks of life have been very encouraging. They have made the directors determined to help build Hospital Aid, Inc., into a strong institution. Of those who have participated in our program, we would like to thank personally, but our thanks are small compared to the gratitude of those who, through your efforts, will find it possible, now and in the future, to have aid when it is needed."

The Frederick County Medical Society has sent this information not only because of its news value, but also that other counties may be interested and set up such a project.

HOWARD COUNTY MEDICAL SOCIETY

THEODORE R. SHROP, M.D.,
Journal Representative

On November 30, 1951, the following officers of the Howard County Medical Society were elected for 1952: *President*, George E. Burgtorf, Jr., *Vice-President*, George E. Groleau; *Secretary-Treasurer*, Theodore R. Shrop; *Delegate*, Frank E. Shipley; *Alternate*, B. Bruce Brumbaugh.

MONTGOMERY COUNTY MEDICAL SOCIETY

L. MARSHALL CUVILLIER, JR., M.D.,
Journal Representative

The Montgomery County Medical Society started the New Year with a meeting on January 15th, at Olney Inn, Olney, Maryland, at which time the new officers presided. Officers for 1952 are: *President*, Frank A. Zack; *Vice-President*, William S. Murphy; *Treasurer*, Charles H. Ligon; *Secretary*, L. Marshall Cuvillier, Jr.

Dinner meetings will be held the third Tuesday of each month, September through June. The dinner is at 7:00 p.m., followed by the Scientific meeting at 8:00 p.m. After the scientific session, a business meeting of the Montgomery County Medical Society is conducted.

The Society extends an invitation to all visiting physicians who may wish to attend.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.,
Journal Representative

The Prince George's County Medical Society have elected the following officers for 1952: *President*, Samuel J. N. Sugar; *Vice-President*, John M. Warren; *Corresponding Secretary*, Benjamin Miller; *Recording Secretary*, Julius Kauffman; *Treasurer*, William B. Hagan; *Delegates*, Waldo B. Moyers and Wolcott L. Etienne; *Alternate Delegates*, William Brainin and James G. Sasscer; *Censor*, Louis M. Jimal.

The Scientific Program for the February meeting of the Society consisted of a discussion of "Management of Cleft Palate" by Dr. Robert E. Moran, of Washington, D. C.

Dr. Benjamin Miller recently returned from Florida where he was convalescing from pneumonia. He states that barracuda are plentiful.

Plans for a Golf Tournament this Spring are being considered by Dr. Fred Musser.

QUEEN ANNE'S COUNTY MEDICAL SOCIETY

WILLIAM G. MARTIN, M.D.,
Journal Representative

Queen Anne's County Medical Society held its last meeting on October 21, 1951, at which time it elected the following officers for 1952: *President*, W. H. Fisher; *Vice-President*, H. F. McPherson; *Secretary-Treasurer*, C. Rodney Layton; *Delegate*, Norman S. Dudley; *Alternate*, Irvin G. Hoyt.

The members of the Society have approved the

establishment of an arthritic clinic in Queen Anne's County. It has also approved a resolution against socialized medicine.

It was agreed, to hold luncheon meetings at trimonthly intervals in the third week of designated months.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D.,
Journal Representative

The annual meeting of the Southern Maryland Medical Society was held in Leonardtown, November 15th. There were 40 physicians present, representing Charles, Calvert, Prince George's and St. Mary's Counties.

Guest speakers were Dr. Brian B. Blades, Professor of Surgery, George Washington School of Medicine, who spoke on "Bronchogenic Carcinoma": Dr. John E. Savage, Associate Professor of Obstetrics, University of Maryland School of Medicine, who spoke on "The Management of the Third Stage of Labor." Dr. Walter D. Wise, President of the Medical and Chirurgical Faculty, also gave a short talk on "Committees of the State Medical Society."

Dr. Robert S. McCeney of Laurel was elected president for the year of 1952 to replace Dr. J. Roy Guyther of St. Mary's County who held that position in 1951.

TALBOT COUNTY MEDICAL SOCIETY

LOUIS S. WELTY, M.D.,
Journal Representative

The Talbot County Medical Society officers for 1952 are as follows: *President*, Martin F. Buell; *1st Vice-President*, J. E. Baybutt; *2nd Vice President*, Kurt Lederer; *Secretary-Treasurer*, Louis S. Welty; *Delegate*, J. Thompson B. Ambler; *Alternate*, William S. Seymour; *Censor*, W. N. Palmer.

Dr. A. McC. Stevens, of Easton, was elected an honorary member.

Doctors W. D. Noble, J. T. Baker and Louis S. Welty were appointed a Medical Economics Committee to cooperate with the Medical and Chirurgical Faculty Committee to Study Certain Phases of Medical Economics. It is the belief of the Talbot County Medical Economics Committee that the first thing urgently needed is for Dr. Moyer's Committee at the State level to set forth a statement of its aims and objects in clear, logical and lucid language.

WASHINGTON COUNTY MEDICAL SOCIETY

W. D. CAMPBELL, M.D.,
Journal Representative

On October 18, 1951, the following officers were elected by the Washington County Medical Society for a period of one year: *President*, Philip J. Hirshman; *Vice-President*, Jack H. Beachley; *Secretary-Treasurer*, Ernest F. Poole; *Delegate*, Robert V. Campbell; *Alternate*, William T. Layman; *Board of Censors*, Samuel R. Wells.

WICOMICO COUNTY MEDICAL SOCIETY

ROBERT LEE BAKER, M.D.,
Journal Representative

The Wicomico County Medical Society, at its December meeting, elected the following officers for 1952: *President*, I. Rivers Hanson; *Vice-President*, Jesse R. Wanner; *Secretary-Treasurer*, Robert Lee Baker; *Delegate*, Osborne D. Christensen; *Alternate Delegate*, William D. Gray.

Dr. J. Edmund Bradley, of Baltimore, was the principal speaker at this meeting. His topic, "Croup" was most timely, and he discussed in detail the types of croup and their treatment.

On January 14th, Dr. Donald H. Stubbs, President of the Southern Anesthesiologists, spoke on "The Anesthesiologist in General Therapy."

The Wicomico County Medical Society was well represented at the Sugar Bowl game in New Orleans, on January 1st. Dr. and Mrs. William B. Long, Dr. and Mrs. I. Rivers Hanson and Dr. and Mrs. Philip A. Insley proceeded via the special train for Maryland rooters.

Library

WHO'S WHO ON LIBRARY COMMITTEE

WHARTON, LAWRENCE RICHARDSON, Surgeon and Gynecologist; received B.Ph. 1907, Hiram College; M.D., Johns Hopkins University Medical School; Associate in Gynecology, Johns Hopkins University; Assistant Attending Gynecologist, Johns Hopkins Hospital; President of Baltimore City Medical Society, 1942; Past Chairman of Section of Gynecology of Southern Medical Association; Past President of Baltimore Gynecological and Obstetrical Society, 1942; Member of American Urology Association; Southern Surgical Association; American Board of Gynecology and Obstetrics (Diplomate); Southern Medical Association; Member of Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1930; author of *Gynecology*, 1947; in addition to numerous articles and monographs on clinical and research problems in Gynecology and Female Urology.

PEARRE, ALBERT AUSTIN, Specialist in Internal Medicine; educated at University of Virginia, B.S. 1920, M.D. 1922; Director of Clinical Laboratory of Frederick City Hospital since 1925; Physician to Hood College since 1925; Physician to Maryland State School for Deaf since 1942; Member of Frederick County Medical Society (President, 1943–44); Southern Medical Society; American College of Physicians; American Medical Association; Medical and Chirurgical Faculty of Maryland (Vice-President, 1943; President, 1950); elected member of the Medical and Chirurgical Faculty Library Committee, 1952–56.

KING, JOHN THEODORE, Physician-in-Chief, Baltimore City Hospitals, 1939–46; Associate Professor of Medicine, Johns Hopkins University; educated at Princeton University, A.B. 1910; Johns Hopkins University Medical School, M.D. 1914; Member, Tuberculosis and Heart Boards, 1917–19; Visiting Physician, 1938–, Johns Hopkins Hospital; Member of Baltimore City Medical Society; Southern Medical Association; American Medical Association; American Society for Clinical Investigation; American Clinical and Climatological Association; Association of American Physicans; American College of Physicians; Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1949; Chief of Medical Service, Walter Reed General Hospital, Washington, D. C., 1942–45; author of numerous technical works.

WOLMAN, SAMUEL, Physician; educated at Baltimore City College, 1899, and Johns Hopkins University, A.B. 1902, and M.D. 1906; Associate in Medicine at Johns Hopkins University; Consulting Physician to Sinai Hospital and Mt. Pleasant Sanatorium; Visiting Physician to Johns Hopkins Hospital; Consultant to Commissioner of Health of Baltimore; Past President of Maryland Tuberculosis Association and Director of National Tuberculosis Association; Member of American Medical Association; Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1930.

KRAUSE, LOUIS A. M., Graduate of the University of Maryland School of Medicine; Diplomate of the American Board of Internal Medicine; Ex-Governor of the American College of Physicians; Member of the Advisory Board of the Faculty of the University of Maryland School of Medicine; Professor of Clinical Medicine; Member of the American Medical Association; Southern Medical Association; Fellow in the American College of Physicians; Member of the Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1950; President of the Baltimore City Medical Society, 1951; Member of School of Oriental Research, Jerusalem, Israel.

WHO'S WHO ON THE FINNEY FUND COMMITTEE

FINNEY, JOHN MILLER TRAIN, JR., Surgeon; educated at Princeton, B.S. 1915; Johns Hopkins, M.D.

1919; Member of the Staff Executive Committee of Union Memorial Hospital; Instructor and Associate in Surgery, Johns Hopkins Medical School; President, Baltimore Council, Boy Scouts of America, 1943; Executive Committee, Baltimore Chapter of the American Red Cross; President, Baltimore City Medical Society, 1950; Member of American Medical Association, Southern Medical Association, American College of Surgeons, Southern Surgical Association, American Surgical Association, Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1942; President, Eastern Surgical Society, 1934–35; President, Southern Society of Clinical Surgeons, 1936–37 and Chairman of Surgical Section, Southern Medical Association, 1940; author of numerous professional monographs and addresses.

HAMBURGER, LOUIS PHILIP, Medical Consultant; educated at Maryland College of Pharmacy, 1888–89; Johns Hopkins, A.B. 1893, M.D. 1897; University of Berlin, 1898–99; President of Baltimore City Medical Society, 1931–32; President of Johns Hopkins Medical Society; Consultant to Baltimore City Health Department, 1937–; served as Member of Committee of Revision of Pharmacopeia of U. S. A. (X Edition); Member of American Medical Association; American College of Physicians; American Association of University Professors; American Association for Advancement of Science; Medical Library Association; Southern Medical Association; Association for Prevention of Tuberculosis; Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1937; author of numerous articles on internal medicine, which have been published in various medical journals.

MCLANAHAN, SAMUEL, Surgeon; educated at Princeton University, A.B. 1923; Johns Hopkins University, M.D. 1927; Assistant Professor of Surgery, Johns Hopkins Medical School; Past Member of Board of Directors of Associated Hospital Service of Baltimore, Inc.; Diplomate of American Board of Surgery; Fellow of American College of Surgeons; Member of Baltimore City Medical Society (President, 1952); American Medical Association; Southern Medical Association; Southern Surgical Club; Southern Surgical Association; Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1948; author of articles on General Surgery in current medical journals.

THOMAS, HENRY MALCOLM, JR., Internal Medicine, B.S., M.D.; Johns Hopkins University School of Medicine, 1916; Associate Professor of Medicine, Johns Hopkins University School of Medicine; Diplomate, American Board of Internal Medicine; Fellow of American College of Physicians; Member of Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1950.

STONE, DOUGLAS H., A.B., M.D.; Harvard, 1937; Instructor in Surgery, Johns Hopkins; Surgeon, Out-Patient Department, Johns Hopkins Hospital; Visiting Staff, Surgery, Church Home and Hospital and Union Memorial Hospitals; Associate Staff, Surgery, Hospital for the Women of Maryland; Courtesy Staff, Surgery, St. Agnes and St. Joseph's Hospitals; Consulting Staff, Surgery, Provident Hospital and Free Dispensary; Member of Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1949.

Civil Defense

CASUALTY CLEARING STATIONS

BRIGADIER GENERAL R. P. WILLIAMS[1]

On assuming duty as Maryland's Chief of Medical Services for Civil Defense, I find that the State has made very commendable progress in its preparation. The State has been very well organized and broad plans and policies have been issued which, when carried into effect, will give Maryland adequate medical service to meet its obligation in case of enemy attack. However, the implementation of these plans has just begun. This phase is the responsibility of local Health Officers. In talking to several of them, it appears that one difficulty lies in the decision as to what should be done first. An organization capable of treating tens of thousands of casualties which have been produced in an instant, must include large numbers of trained individuals who have been organized into units, furnished with necessary equipment and supplies, and they also must have suitable places in which to work. This is a vast undertaking, including innumerable details, responsibilities and decisions. A start must be made somewhere. This is the time to decide where.

The number of casualties, considered in relation to the small number of professional people available, indicates that the bulk of the work will fall upon a large number of non-professional volunteers. Now is the time to train the volunteers and assign them to organizations.

The casualty clearing station is the place to which all of the casualties will be brought and where they will first be given the professional care of doctors, nurses and pharmacists. Each of these stations is designed to treat 600 casualties in 24 hours. These factors indicate the extreme importance of the casualty clearing station in meeting a disaster. Properly trained and equipped casualty clearing stations will reduce the number of deaths by half. Without properly functioning stations of this nature, the hospitals will be overrun and their professional people will be handicapped in their work. With all of this in view, it seems best to focus our attention now on the casualty clearing station.

It is not necessary for all of the individuals required by the table of organization to be present in order to organize a casualty clearing station. As soon as key personnel have been gathered the completion of organization and training can be turned over to them. It is suggested that the local Health Officer select a leader who is interested in Civil Defense and ask that individual to start gathering the staff. This leader should be picked on the basis of enthusiasm and ability. He or she need not necessarily be a doctor or a nurse. In many instances a preacher, teacher, member of the P.T.A., or a pharmacist, may best serve. Then, as the organization progresses, the professional people can be added. The recruiting of volunteer first aid workers and nurses' aides should be started early, as many of these people will need training for their duties. The Red Cross has offered to train them.

Each casualty clearing station will need from five to ten first aid stations to gather casualties, give first aid, and transport them to the casualty clearing station. Each of these first aid stations will consist of three first aid teams. Each team comprises one leader and eight litter bearers, all trained in first aid.

Equipment and supplies for 150 casualty clearing stations and their satellite first aid stations is now being purchased from both Federal and State funds. The first of this equipment will be ready for issue in several weeks. The casualty clearing stations should be well organized in order to receive this equipment.

During the week 7 to 12 January, 1952, I will be attending the Federal Civil Defense Staff College at Olney. Upon completion of this course, I propose to visit all of the local Health Officers as rapidly as I can, in order to make myself available to them, and to assist in this work. Meanwhile, I hope that the first steps in organization will have been taken before my visit.

In first focusing attention upon casualty clearing stations, there is no intent to detract from the importance of all of the other Civil Defense activities.

[1] Chief, Medical Services, Civil Defense, Maryland State Department of Health.

It is believed that this is where we should begin and as soon as the organization of these forward stations is well developed, we will turn our attention to other echelons.

ALLEGANY-GARRET COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.,
Journal Representative

Dr. Leslie E. Daugherty, Medical Director for Civil Defense in Allegany County, announces the following appointees to the Steering Committee: Drs. William F. Williams, W. Alfred Van Ormer, Benedict Skitarelic, John K. Rozum, W. Oliver McLane, Jr., and J. Norman Reeves.

THE MEDICAL PROFESSION AND CIVIL DEFENSE

J. WILFRID DAVIS, M.D.[1]

The first of the year 1952 is accompanied by an unwelcome carry-over from the year previous, the threat of enemy action in our own country. Particularly, the shadow of the atomic bomb darkens the brightness and high hope which the beginning of a new year brings to most human beings.

Enemy attack in almost any form will entail casualties possibly numbered in scores of thousands. Physicians will be in most urgent demand. They will stand in the forefront of the battle. However, they will be appallingly ineffective unless they are well organized and properly directed. The medical section of our Civil Defense Organization is designed to provide necessary plans and leadership. This Organization requires and deserves the eager cooperation of every physician who can serve in Civil Defense.

When confronted with dangers of other kinds, physicians of Maryland have marched forward shoulder to shoulder to meet and overcome the threat that faced them. In the same spirit they will do their part in Civil Defense.

Let us hope that Maryland will never experience an enemy attack. Another atomic bomb may never fall. But a man insures his house even though he expects that fire may never destroy it. We should hope for the best but prepare for the worst. Looking for a ray of light in the shadow, let us not fail to note that even the threat of such dire things as atomic, biologic and chemical warfare in our country carries with it some solace—the satisfaction felt by physicians planning and working together in a great and worthy cause.

[1] Deputy Director, Baltimore City Civil Defense Health Service.

INSURANCE ECONOMICS SOCIETY OF AMERICA

Urges Shift In Old Age Assistance Planning

The general budget would be relieved of an annual burden of $800 to $900 million if the Federal government's share of current Old Age Assistance was placed under the Old Age and Survivor's Insurance Program, according to H. Albert Linton, president of the Provident Mutual Life Insurance Co. and president of the Life Insurance Association of America.

Mr. Linton told the closing session of the association's 45th annual meeting that "such a move would probably reduce political pressures. We of this generation would understand more fully the true costs of pensions. If benefit levels were to be raised for those currently on the rolls, money would have to be found immediately to pay the increased costs. We would, therefore, be less likely to promise unduly high benefits for others to pay in the future. There would be no temporary excess of income over outgo in the O.A.S.I. system as at present to make it appear feasible to set benefits at unsound levels which could impose a future dangerous burden upon the economy of the country."

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

The New Communicable Disease Chart

In 1934 and again in 1940 and 1946, the Baltimore City Health Department has issued a chart designed to show the isolation requirements and additional clinical and epidemiological information for some of the more important communicable diseases, particularly those that affect children.

Charts of like nature have been used in some of the counties of Maryland and in other States, and they have been useful both to the members of the medical profession, and also to Health Department physicians and public health nurses, and school teachers.

On April 20, 1951, the Baltimore City Health Department adopted its latest revised Communicable Disease Chart as Regulation 2 pursuant to the authority of City Ordinance No. 217, Approved June 20, 1945.

The revised edition, based on up-to-date nationally recognized sources, was prepared in close collaboration with the health officers of Baltimore County and Anne Arundel County and the Maryland State Department of Health. The Commissioner of Health of Baltimore City welcomes this opportunity of presenting the newly revised chart to the readers of the *Maryland State Medical Journal.*

Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

REQUIREMENTS FOR COMMUNICABLE DISEASES

Pursuant to Ordinance No. 217, Approved June 20, 1945, and Ordinance No. 693, Approved December 2, 1946, the following regulation for the control of communicable diseases has been adopted, effective April 20, 1951.

This regulation, Regulation 2—Control of communicable disease, has been prepared in chart form for the use of health officers, physicians, school authorities, public health nurses and others, to serve as a ready reference to facts regarding several of the more important communicable diseases and the requirements of the Baltimore City Health Department concerning them.

1 Disease and Incubation Period	2 Common Early Signs and Symptoms	3 Method of Infection	Isolation Requirements					9 Remarks
			4 Isolation of Patient	If Patient and Contacts Remain at Home		7 Isolation of Household Contacts If Patient Goes to Hospital or Contacts Leave Home	8 Isolation of Incidental Contacts	
				5 Isolation of Contacts Under 16	6 Isolation of Adult Contacts			
CHICKENPOX Incubation Period: 11-24 days. Usually 13-16 days.	In children the first symptom noticed is usually the rash which when first seen consists of small blisters that have developed from small pimples. In a day or two crusts form which fall off in about 14 days. The eruption comes out in crops so that there may be pimples, blisters and scabs all within a small area of the skin.	Contact with a previous case. Infection believed to be contained in discharges from throat and nose and in the skin lesions.	Until recovery. Usually not over 7 days after first appearance of rash.	No.	No.	No.	No.	Very communicable. A mild disease and seldom any after-effects. Important because of possible confusion with smallpox. The long and variable period of the incubation and the mildness of the disease do not warrant the isolation even of susceptible contacts.
DIPHTHERIA Incubation Period: Minimum less than 1 day; maximum, indefinite. Usually 2-5 days.	Sore throat is usually the first symptom in patients over a year old. In very young children it is apt to be croup. In the latter there may be no patches showing, but in the former they can always be found in "typical" cases either on the throat itself, tonsils or palate, sometimes on all of them. Some cases look like simple tonsillitis. In nasal cases discharge from nose occurs which usually excoriates the upper lip and may be bloody. Diphtheritic croup means diphtheria of the larynx. It is an exceedingly dangerous form of the disease.	Contact with a previous case or carrier. Discharges from throat and nose convey infection. Unpasteurized milk may convey infection. Often spread through mild, unrecognized cases, or by persons harboring the germs of the disease, though giving no evidence of having had an attack of diphtheria (carriers).	Until 2 successive cultures each from throat and nose taken at least 24 hours apart contain no virulent diphtheria bacilli.	Yes. Until patient is released from isolation and cultures from both throat and nose show no virulent diphtheria bacilli.	No. *Provided* (a) patient is properly isolated, and cultures from both throat and nose show no virulent diphtheria bacilli; and (b) occupation of contact does not involve the handling of food or bring the contact into close association with children.	No. *Provided* cultures from both throat and nose show no virulent diphtheria bacilli.	No.	Very dangerous, both during attack and from after-effects. The younger the child the greater the danger from diphtheria. There is a great variation of type, and mild cases are often not recognized unless a culture is taken or subsequent paralysis develops. CHILDREN MAY BE PROTECTED AGAINST DIPHTHERIA BY TOXOID INOCULATION. EVERY CHILD SHOULD RECEIVE A SERIES OF PROTECTIVE INOCULATIONS OF DIPHTHERIA-PERTUSSIS-TETANUS TOXOID BEGINNING EARLY IN THE FIRST YEAR OF LIFE, AND LATER, BOOSTER DOSES OF THIS MATERIAL.
GERMAN MEASLES Incubation Period: 12-21 days from exposure to initial symptom, usually 14-16 days. Usually 18 days from exposure to appearance of rash.	Illness usually slight. Onset sudden. Lymph nodes in back of neck usually enlarged. Rash often first thing noticed. Cold in head not a prominent symptom. May have fever, sore throat, and eyes may be inflamed. Rash variable; may resemble measles or scarlet fever, or both.	Contact with a previous case. Discharges from throat and nose of a patient convey infection.	Until recovery.	No.	No.	No.	No.	A mild disease, occasionally confused with measles or scarlet fever.
MEASLES Incubation Period: 8-12 days from exposure to initial symptom, usually 9 or 10 days; 11-15 days from exposure to appearance of rash.	Begins with fever followed by symptoms like cold in the head, with running nose, sneezing, inflamed and watery eyes. The rash is usually first seen behind the ears, on forehead and face; it is blotchy and usually dusky red in color.	Contact with a previous case. Discharges from throat and nose of a patient, especially in the early days of the disease before the rash appears, convey infection.	Until recovery.	No.	No.	No.	No.	Very communicable, especially during the first few days before the rash appears. Practically everyone who has not had the disease is susceptible. Because of these facts measles occurs characteristically in epidemics. *Efforts to cut these epidemics short through the isolation of contacts are seldom successful and cause much inconvenience and loss of school time.* The primary object should be the prevention of deaths through adequate medical and nursing care. Parents should be instructed in early symptoms and told to keep the child home if these develop. If found in school, the child should be sent home and the Health Department notified of name and address. Measles is very dangerous to children under 3 years of age. School children nearly always recover unless they are in poor physical condition or are not properly cared for during illness.
MENINGOCOCCUS MENINGITIS, MENINGOCOCCEMIA Incubation Period: Difficult to determine. Said to be 1-5 days, usually under 4 days.	Onset usually sudden, with vomiting, fever, headache and stiffness of neck.	Contact with a previous case or carrier. Discharges from throat and nose of a patient or carrier convey infection.	Until end of the febrile stage	No.	No.	No.	No.	Infection apparently conveyed chiefly by carriers. Overcrowding should be avoided in living quarters and especially in sleeping rooms, for such overcrowding apparently increases greatly the risk of infection.
MUMPS	Swelling of side of neck in front of and	Contact with a pre-	Until swelling dis-	No.	No.	No.	No.	Very communicable. Inflammation of

COCCEMIA **Incubation Period:** Difficult to determine. Said to be 1-5 days, usually under 4 days.		from the nose of a patient or carrier convey infection.						quarters and especially in sleeping rooms, for such overcrowding apparently increases greatly the risk of infection.
MUMPS **Incubation Period:** **12-26 days. Usually 17-21 days.**	Swelling of side of neck in front of and below the ear is usually the first symptom noticed. Other early symptoms include chilliness, headache and fever.	Contact with a previous case. Discharges from throat and nose of a patient convey infection.	Until swelling disappears.	No.	No.	No.	No.	Very communicable. Inflammation of testes or ovaries may occur after the age of puberty. Otherwise not a serious disease.
POLIOMYELITIS **Incubation Period:** **Usually 7-14 days.**	Onset sudden, with fever, dull pain on bending neck forward, pain on being handled, headache and vomiting. Sometimes sudden development of weakness of one or more muscle groups.	Apparently contact with a healthy carrier of the virus or with a recognized or unrecognized case. Discharges from the throat and nose of a carrier or a patient apparently convey infection.	Until end of the febrile stage.	No.	No.	No.	No.	Infection apparently conveyed chiefly by throat and nose discharges of carriers. Virus has been found in bowel discharges of infected persons. After-effects often paralysis of certain muscle groups, transitory or permanent. Death is usually due to paralysis of respiratory muscles.
SCARLET FEVER **Incubation Period:** **1-7 days. Usually 2-3 days.**	Onset usually sudden, with headache, fever, sore throat, and often vomiting. Glands (lymph nodes) of neck usually enlarged. Usually within 24 hours the rash appears as fine, evenly diffused bright red dots. The rash is seen first on neck and upper part of chest, and lasts 24 hours to 10 days, when it fades and the skin peels in scales, flakes or even large pieces.	Contact with a previous case or carrier. Discharges from throat and nose, suppurating glands or ears of a patient. Unpasteurized milk may convey infection. Often spread by mild, unrecognized cases.	Until the mucous membranes of the throat and nose appear normal and until all abnormal discharges from the throat, nose, ears and suppurating glands have ceased; *provided* that such isolation shall continue for not less than 7 days and not more than 90 days from onset.	No.	No.	No.	No.	Running ears, discharging noses or suppurating glands may greatly prolong the infectious period. Mild unrecognized cases, or carriers are important in spread. Very mild cases may show little rash, and the peeling may not be noticeable.
STREPTOCOCCAL SORE THROAT (SEPTIC SORE THROAT) **Incubation Period:** **Same as scarlet fever.**	Same as scarlet fever but without the rash.	Same as scarlet fever.	Same as scarlet fever.	No.	No.	No.	No.	Same as for scarlet fever, but omitting references to rash and peeling.
SMALLPOX **Incubation Period:** **7-21 days. Usually 12 days from exposure to initial fever and 15 days from exposure to appearance of rash.**	Onset sudden, usually with fever, headache and severe backache. About third day usually upon subsidence of constitutional symptoms there develop red pimples felt below the skin and seen first about the face and wrists and mostly on exposed surfaces. They form small blisters and 2 days later become filled with yellowish matter. Scabs form which begin to fall off about the fourteenth day. In mild cases the pimples and blisters may closely resemble those found in chickenpox.	Contact with a previous case. Discharges from throat and nose convey infection; contents of pustules are also believed to convey infection.	Until 14 days after onset and until skin has healed. Patient usually required to accept hospitalization in the Sydenham Service at Baltimore City Hospitals.	Yes. Until 21 days after isolation of patient has been terminated. *Vaccination required.* If vaccinated within 3 days after first exposure and if residence is changed may be released from isolation as soon as Health Department determines vaccination has been successful.	Yes. Until 21 days after isolation of patient has been terminated. *Vaccination required.* If vaccinated within 3 days after first exposure and if residence is changed may be released from isolation as soon as Health Department determines vaccination has been successful.	Yes. Until 21 days after removal. *Vaccination required.* If vaccinated within 3 days after first exposure may be released from isolation as soon as Health Department determines vaccination has been successful.	Yes. Until 21 days after last exposure. *Vaccination required.* May be released from isolation as soon as Health Department determines vaccination has been successful.	Very communicable. Cases of modified smallpox may be and often are so slight as to escape detection. Existence of disease may be concealed. A severe type of infection may result from exposure to a mild case. Every child should be vaccinated before the age of one year.
WHOOPING COUGH **Incubation Period:** **2-14 days. Usually 5-8 days.**	Begins with cough which is worse at night. Symptoms may at first be very mild. Characteristic "whooping" develops in about 2 weeks, and the spasm of coughing sometimes ends with vomiting. If a child vomits after a hard spell of coughing, he probably has whooping cough. Some children with mild whooping cough never "whoop" or vomit.	Contact with a previous case. Discharges from throat and nose, especially in the early stages before the "whoop" begins.	Patient restricted from associating with children or attending public assemblies until 28 days after onset and until recovery, but not more than 8 weeks.	No.	No.	No.	No.	After-effects often very severe and disease causes great debility. Relapses are apt to occur. Second attack rare. Especially communicable for first week or two before the "whoop" occurs. Great variation in severity of cases. Often fatal in young children and the weak and aged. Over half the deaths are in children less than a year old and over 95 per cent are in children under 5 years of age. CHILDREN MAY BE PROTECTED AGAINST WHOOPING COUGH BY PREVENTIVE INOCULATION. EVERY CHILD SHOULD RECEIVE A SERIES OF PROTECTIVE INOCULATIONS OF DIPHTHERIA-PERTUSSIS-TETANUS TOXOID BEGINNING EARLY IN THE FIRST YEAR OF LIFE, AND LATER, BOOSTER DOSES OF THIS MATERIAL.

Issued by Bureau of Communicable Diseases
MYRON G. TULL, M.D., Director
HUNTINGTON WILLIAMS, M.D., Commissioner of Health

Insurance

BLUE CROSS

The year 1951 was one of great activity and important change for Blue Cross. It had hardly begun when Director J. Douglas Coleman announced that he was leaving to accept a position as Vice-President of both The Johns Hopkins University and The Johns Hopkins Hospital. He has assumed the responsibilities of managing the fund raising program of these two institutions. Mr. Coleman was the original Director of Maryland's Blue Cross and had steered its course from its infancy to an enrollment of 800,000. It was fortunate indeed that Mr. R. H. Dabney, his assistant for four years, was available as Mr. Coleman's successor.

The next major change was the move in May to 200 West Baltimore Street. The offices on Baltimore Street and Fayette Street were consolidated on the first two floors and mezzanine of the Butler Building. Everybody is now settled and all is running very smoothly. Visitors are welcome at any time to inspect the new headquarters.

Before and during these changes, it was becoming more and more evident that certain alterations had to be made in the Blue Cross benefits and rates. The fact that hospital costs (and consequently Blue Cross') had increased, made the rate change inevitable. Therefore, on December first new rates and improved benefits were put into effect. Included in the latter, are maternity benefits—up to $75.00 credit for any one pregnancy—and also 21 days of hospital care for each hospital case, provided stays are separated by at least 90 days.

With the above changes Blue Cross has continued to grow. In the past year over 40,000 new members have joined making a total (as of December 1st) of 840,512.

This information was presented at the annual Blue Cross Corporation dinner held Wednesday, January 30, at the Sheraton Belvedere Hotel. Among those who attended were, the member hospital administrators, the Board of Directors of Maryland Hospital Service, Incorporated and various administrative personnel of Blue Cross.

DEFENSE DEPARTMENT, UMT COMMISSION SUPPORT AMA ON MEDICAL STUDENT DEFERMENT. CAPITOL CLINIC VOL. #3, NO. 3

Defense Department and National Security Training Commission are in agreement with the American Medical Association that pre-medical and medical students, after six months of Universal Military Training, should be deferred from service in the reserves until completion of their schooling and internships. The two agencies presented their views before the House Armed Services Committee, which is holding hearings on bills to implement UMT. If Congress puts UMT into effect, it will be run by Defense Department but supervised by the Civilian Commission.

For the first year at least, deferment would not be an important factor, as Defense Department contemplates starting out with only 60,000 eighteen year old volunteers. Eventually as many as 800,000 inductees could be trained annually.

Hospital News

LICENSING OF HOSPITALS

H. G. FRITZ[1]

Maryland has had a hospital licensing program since 1945. The Law[2] enacted that year by the Legislature provided for the licensing of hospitals and authorized the State Board of Health to promulgate rules and regulations prescribing certain minimum standards for hospitals.

Currently 221 institutions, with 24,116 beds fall within the purview of the program. The Law defines a hospital as "any institution which maintains and operates facilities for the care and/or treatment of two (2) or more non-related persons as patients suffering mental or physical ailments."

ADVISORY BOARD

The Law specifically places responsibility upon the State Board of Health for the administration of the program. It also establishes an Advisory Board which "makes recommendations to the State Board of Health" and assists "in the establishment of minimum standards." This Board[3] is composed of three members nominated by the Medical and Chirurgical Faculty and four members nominated by the Maryland-District of Columbia Hospital Association. Of the Hospital Association nominees, two are required to be hospital administrators, one a hospital trustee, and at least one must be a member of the Medical and Chirurgical Faculty. Dr. Winford H. Smith is currently Chairman of this Board.

This Board collaborated with the personnel of the Department of Health in preparing the original rules and regulations and has reviewed and recommended to the State Board of Health all later modifications. It meets, on call, to consider problems as they arise. Problems stem largely from nursing homes which have failed to comply with regulations. Decisions must be made as to what will be accepted as compliance, as well as an acceptable schedule of progress toward complicance, or recommendation of closure to the State Board of Health.

SCOPE

Institutions covered by the program range from nursing homes with two or three beds to large ones having as many as 100 beds, and hospitals in all categories and sizes.

Institutions now listed are grouped as follows:

Category	Number of Institutions	Number of Beds
General Hospitals	42	8,221
Special Hospitals		
Mental	17	10,113
Tuberculosis	6	1,252
Chronic Disease	4	561
Others	11	393
Nursing homes	141	3,576
	221	24,116

The number of institutions licensed has not been subject to much fluctuation. Few new hospitals have been built, most construction in recent years being in the form of additions to existing institutions. The number of new nursing homes established has balanced with the number closing.

REGULATIONS

Because of the diversity of facilities needed in the various classes of institutions, two sets of regulations are in use. One set covers acute general and special hospitals. Nursing and convalescent homes are covered by the second set.

The Regulations deal with interpretations of the law for the purpose of defining the institutions re-

[1] Chief, Division of Hospital Services, State Department of Health.

[2] Chapter 210, Laws of Maryland 1945.

[3] Winford H. Smith, M.D. (6-1-53); Mr. William L. Galvin (6-1-54); William D. Noble, M.D. (6-1-56); Mr. P. J. McMillin (6-1-52); Mr. J. Douglas Colman (6-1-55); J. Oliver Purvis, M.D. (6-1-54); and I. Ridgeway Trimble, M.D. (6-1-52).

quired to obtain a license, but largely with hospital services and facilities required to be maintained. In areas where other agencies carry responsibilities and have established regulations or codes, the regulations for this program are not spelled out in detail. For instance, in the case of fire safety, the State or local fire authorities are called upon to make inspections and submit recommendations in line with the regulations under which they function. Institutions must comply with these recommendations to qualify for a license. The same procedure is used in the field of Sanitary Engineering covering water supply, sewage disposal, sanitary inspections and building codes.

Functioning in this manner the State Department of Health coordinates the inspections of other agencies adding only those areas not previously covered such as space standards for beds, facilities, and other hospitals aspects.

PERSONNEL

The use being made of other inspecting agencies and bureaus and divisions within the Department leave only the specific hospital elements of an institution to be covered. The field work, that is interviews with persons wishing to establish a new institution, routine inspections and follow up on recommendations, is done by three Hospital Advisors. Hospital Advisors are nurses with college degrees, supplemented by experience in public health or hospital administration.

Shortly after the Division of Hospital Services was established to administer the hospital construction program under the Federal Hospital Survey and Construction Act (Hill Burton Bill), the licensing program was transferred to this Division. This brought into direct relationship with the hospital licensing program the services of a hospital administrator who functions as Chief of the Division, an architectural engineer, an architect, and the part time services of a consultant dietitian. In cooperation with the Hospital Advisor, the services of these specialists are used as the need arises.

PROGRESS

Results of the program at the end of five years cannot be tabulated in the form of a profit and loss statement. However, there is tangible evidence that it has effected an improvement of hospital facilities, services and safety throughout the State.

Early reports from fire authorities were voluminous because of numerous hazards and deficiencies found. Recent reports in most instances are certifications to the effect that there are no current violations. The violations consisted of such conditions as non-functioning fire exit doors. In others, exits were blocked by equipment. In some cases fire exit lights were not lighted. Fire extinguishers were found empty or outdate. Inflammable material such as paint and oil mops, were improperly stored. In some cases additional fire exits and fire escapes were required. Where defective wiring was found it was ordered replaced. The number of extension cords plugged into one outlet was found to be excessive and ordered reduced in number. Fire alarm systems were ordered installed. These and many other hazards which previously had been neglected or overlooked have been corrected. Inspections at regular intervals insure against another accumuation of these and similar hazards.

The Department has added the requirement that instructions for procedure in case of fire be written and posted throughout the institution.

From the point of view of hospital services, the improvement in nursing homes has been more dramatic than in general and special hospitals. At the beginning of the program nursing homes were categorized in three groups. The first group consisted of those homes which essentially met the regulations. The second group was made up of homes which could be brought into compliance with certain changes or improvements. The third group was made up of homes which showed no possibility of being brought into compliance.

The closure of the third group has been slow because of the dearth of nursing homes and chronic disease hospital beds. It can be reported that with only two exceptions none of this group is in operation today. The two remaining of this group have made considerable progress toward compliance, having met fire and safety requirements.

New nursing homes are inspected and required to comply before opening. The new ones, having been approximately equal to the number closing have therefore raised the general average for all nursing homes.

In addition to improvement in the physical plants very important progress has been effected in the functioning of nursing homes. Every nursing home

now has in attendance a "principal physician." His affiliation with the institution is a matter of record with the State Department of Health. His commitment includes emergency calls and responsibility for the medical policies of the institution. The medical profession's increasing interest in geriatrics is assumed to be a contributory factor to the physician's willingness to establish this type of relationship with nursing homes. The influence of the principal physician, coupled with the insistence of the Health Department is effecting the establishment of improved medical records and better standards of care.

Patients are no longer placed in beds in overcrowded rooms. Standards of floor and window areas are enforced, thus insuring adequate space, light and ventilation.

In the area of hospitals there has also been considerable progress. One new hospital is under construction and will replace an old one which was considered too hazardous to warrant remodeling. Another hospital has under construction an addition which will provide a satisfactory solution to several conditions which were in violation of regulations for licensing.

NEW CONSTRUCTION

The progress commented upon has in many cases been difficult to accomplish. There is still much to be attained before it can be reported that all hospitals and nursing homes are in full compliance. Some problems will not be overcome until hospitals find sufficient money to construct additions or new buildings of sufficient capacity to accommodate their present overload, the unmet need for hospital beds, viz: the waiting lists and the patients now housed in facilities which cannot economically be made to meet modern standards.

FISCAL ASPECTS

Cost of construction and equipment has reached such a high point that institutions are finding it difficult to obtain funds in sufficient amounts to proceed with construction programs. The Hill Burton Bill was intended to reduce the local cost through Federal Grants. Since 1946 when the Hill Burton Bill became law, costs have increased beyond the amount of Federal assistance. Hospitals are therefore utilizing buildings and equipment which they would prefer to replace but find it impossible to do so. In the interim, the licensing program is being directed toward making these structures safe by providing fire fighting and prevention facilities, fire exits, and keeping them free of hazards.

The nursing home situation is comparable. High construction costs and limited ability of patients or their relatives to pay high rates over an extended period make it impossible and impracticable for operators to erect new buildings. Nursing homes are therefore established in converted dwellings. Under the licensing program these buildings are maintained at safe standards.

Patients needing nursing home care frequently are dependent upon limited personal resources, support from relatives or welfare grants. Insistence upon installation of expensive equipment and remodeling, except in safety measures, is scheduled at a rate consistent with income. After safety, adequate food and bedside care is preferred to capital improvement. During periods when progressive improvement is being accomplished and adequate food and service are maintained, "provisional licenses" are issued.

EDUCATIONAL ASPECTS

The services of all personnel of the Department are freely called upon for consultations in their respective field. On occasion calls have been made upon the services of individuals not in State employment, for advice or consultation with personnel of institutions having special problems.

Plans are being developed for short courses of instruction for nursing home operators on subjects such as housekeeping, medical records, dietary, and other nursing home services.

SUMMARY

The hospital licensing program is a continuous effort to upgrade institutions falling within the purview of the law establishing the program. Conditions as they existed when the program was initiated compared with those prevailing currently reveals that considerable progress has been made, especially in nursing homes.

High cost of construction, service and supplies, and limited personal resources and grants from public funds retard the rate at which complete compliance with regulations can be accomplished.

Woman's Auxiliary to the Medical and Chirurgical Faculty

NEWS OF COMPONENT AUXILIARIES

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

The Woman's Auxiliary to the BALTIMORE CITY MEDICAL SOCIETY, at the February 6, 1952 meeting heard Mr. John W. Payne, Executive Director of the Good Will Industries, explain how the Good Will Industries manage to assist the handicapped without Federal Aid.

BALTIMORE COUNTY AUXILIARY held its annual election of officers at the home of the President, Mrs. George E. Urban, on December 14th. Their new officers are as follows: Mrs. Martin E. Strobel, President; Mrs. Howard W. Frederickson, Vice-President; Mrs. Charles W. Kerr, Recording Secretary; Mrs. James E. Peterman, Corresponding Secretary; Mrs. Elliott E. Flick, Treasurer.

Members of the Auxiliary to the PRINCE GEORGE'S COUNTY MEDICAL SOCIETY report that their fashion show and luncheon to raise funds for a Nurse's Scholarship was a great success. Because of their generosity in contributing to various health drives throughout the year and in giving such a substantial donation to their Doctors' Library, the Auxiliary will require additional funds before this scholarship can be established.

Rumor has it that the WASHINGTON COUNTY AUXILIARY is considering the idea of holding a Charity Ball. If they do, we hope that its success will make it a yearly event of importance in Hagerstown.

We have no report from DORCHESTER, MONTGOMERY, CECIL OR FREDERICK COUNTY AUXILIARIES.

THE AUXILIARY CIVIL DEFENSE PROGRAM

MRS. E. IRVING BAUMGARTNER

As members will recall, The Woman's Auxiliary to the Medical and Chirurgical Faculty pioneered in requesting all women's organizations and clubs to hold Civil Defense meetings, to show Civil Defense movies, and to distribute a pamphlet called "Survival Under Atomic Attack." Several prominent National and state-wide women's groups as well as a great many independent local associations adopted our suggestions.

As a result, Civil authorities were flooded with requests for speakers and for the two Civil Defense movies then available. Our State Auxiliary initiated this program of Civil Defense due to suggestions made at the Chicago Conference of the Woman's Auxiliary to the American Medical Association, of which we are a part, and which was attended by our President and President-Elect.

This year Mrs. Yeager and Mrs. Williams have returned from the Chicago Conference with additional suggestions from our National body for work in Civil Defense. We should encourage our own members and those of other Civic Organizations, and all individuals in our Communities, to have their blood typed as soon as possible, and to obtain identification tags stamped with their blood type, name, and address.

Every one making the effort to take a First Aid course or to contribute blood to the blood bank, acts not only for the public safety but in self defense in case of disaster. For my own part, as your Auxiliary Chairman of Civil Defense, I have taken the orientation course conducted by the Federal and State Civilian Defense officers, to better qualify myself for the responsibility of informing the Auxiliary and the public about Civil Defense needs.

Auxiliary members and members of other interested groups, can render public service to their communities by making a door-to-door survey of the houses in their immediate neighborhood to learn whether the householders have prepared a First Aid kit, a shelter and food supplies in case of emergency. They should be asked whether they have taken necessary fire precautions; a First Aid course; given blood; had their blood typed, acquired identification

tags; and have read the following pamphlets, "Survival Under Atomic Attack," published last year and the newer ones "Fire Fighting for Householders," "Civil Defense Household First Aid Kit" (to be kept with the kit), and "Emergency Action to Save Lives." The latter pamphlet explains what rescuers should not attempt if they have not studied First Aid. In rural areas, where animals and crops must be protected from destruction and contamination, people should be asked to read "What You Should Know About Biological Warfare." All these pamphlets are procurable from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for the sum of five or ten cents per copy. If component Auxiliaries, and other organizations, do not choose to buy and distribute these pamphlets, individual members might purchase a few to distribute during their neighborhood door-to-door survey. At least, neighbors should be given the source from which they may be obtained and informed of the necessity of reading them.

This will emphasize further the most important aspect of Civil Defense,—the self-dependence of each citizen and family. It is a fact that preparations made by the individual ahead of time, will be his only protection. All public assistance will be needed elsewhere. Survival will be dependent upon individual effort.

The Maryland State Auxiliary has informed its Component Auxiliaries of the location of Area Civil Defense Directors. Reliable information indicates that Doctors' wives can serve best by working, under the Doctors, in their local Casualty Clearing Stations. A great many wives of Physicians are trained nurses, dietitians, or have done some type of hospital work. For this reason Civil Defense authorities feel that we may be most useful by helping in both the City and Counties in the organization of medical supplies and other work attendant upon the establishment of Casualty Clearing Stations. Members of non-medical women's organizations should be urged to become Civil Defense Officers, as they would make excellent Air Raid Wardens, Auxiliary Police, etc. Preferably, we should sign up for service in the nearest Casualty Clearing Station, which would be composed largely of medical personnel.

In rural areas, particularly, the doctor and his wife are Civil Defense! The doctors have helped plan the Civil Defense program and some of them have taken the special orientation course in order to better protect their communities. For rural or city Auxiliaries desiring Civil Defense program material, there is a speaker's kit available on "Biological Warfare" from Thomas Meecham, Director of Public Liaison Division, Public Affairs Office, Federal Civil Defense Administration, Washington 25, D. C. A doctor or one of your own members could give a talk on this timely subject.

Finally, there are three excellent Civil Defense movies, which were not available last year and which Auxiliaries and other organizations can obtain from their local Area Civil Defense Directors or Coordinators. These films are "Tale of Two Cities," 12 minutes, "Survival Under Atomic Attack," 9 minutes, and "Fire Fighting For Householders," 9 minutes. These are 16 m.m. sound track films and, in the City, come spliced together. In Baltimore City, Civil Defense authorities will provide a projector and operator to show these pictures. In the Counties the authorities will make the best possible facilities available. For instance, in some Counties a speaker will be provided who will also operate the movie projector.

We must continue our program of urging not only our Auxiliaries but all other Civic groups as well, to devote one meeting a year to Civil Defense. This is especially important in Maryland which is one of the critical target areas of the United States. Maryland is always mentioned as a known target for enemy bombers. Furthermore the Department of Defense tells us enemy bombers could successfully complete their mission. We shall have helped to meet this grim challenge by making the individual citizen aware that Civil Defense is essentially self defense, and that everyone must personally take the initiative to protect himself, his own family, home, and community.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

STUDENT NURSE RECRUITMENT

MARGARET COURTNEY, R.N.

To help meet the continuing demand for nurses a Joint Committee on Careers in Nursing has been appointed by the Joint Board of Directors of the Three Maryland State Nursing Organizations—Maryland State Nurses Association, Maryland State League of Nursing Education, and the Maryland State Organization for Public Health Nursing. This committee will work in cooperation with members of allied professions and other groups in the interest of securing well-qualified students for schools of nursing. It will endeavor to keep before the public the opportunities and satisfactions of a career in nursing. It will provide prospective students with information regarding approved schools of nursing. The committee will recruit not for individual schools, but for the nursing profession.

Recognizing that physicians are in strategic positions to interest and guide young women in their choice of a career, this committee urges that each physician participate in this effort to meet present and future nursing needs. Individual guidance such as this will be of inestimable value in securing more students for our schools of nursing.

Current and detailed information regarding entrance requirements, programs of study, etc., is essential for guidance. Such information can be secured from individual schools of nursing or from the Joint Committee on Careers in Nursing, 1217 Cathedral Street, Baltimore 1, Maryland. The committee would welcome inquiries from physicians or from prospective students in nursing. Arrangements for personal interviews can be made by writing to the Committee or by calling Vernon 7567.

THE JOHNS HOPKINS HOSPITAL SCHOOL OF NURSING

Refresher Program

The Johns Hopkins Hospital School of Nursing offers a four weeks refresher program to graduate nurses. April 15–May 12, 1952.

The program will include a minimum of thirty hours of conferences and classes, with nursing practice providing a weekly schedule of forty hours. Topics to be discussed will be as follows:

Present Concepts of Patient Care

Review of Systems of Measurement, Problems in Dosage and Solutions, and Administration of Drugs

Basic Nursing Care Including Review of Medical and Surgical Asepsis Nursing Care of Patients with Medical and Surgical Conditions—Medical and Psychological Therapy, Pre and Post Operative Care, Early Ambulation—Use of New Drugs and Antibiotics—Diet Therapy—Oxygen Therapy—Radium Therapy—Use of Respirators—Traction—etc.

Graduate nurses interested in this program should apply not later than April 1st, 1952 to The Director of the Nursing School and Nursing Service, The Johns Hopkins Hospital, Baltimore 5, Maryland.

MARYLAND STATE NURSES ASSOCIATION

M. RUTH MOUBRAY, *Executive Secretary*

At the annual convention of the Maryland State Nurses Association held in November 1951 the terms of some of the officers terminated and new officers were elected. For your information we are listing below the present officers of the Maryland State

Nurses Association. All of them may be addressed at the headquarters office of the Maryland State Nurses Association, 1217 Cathedral Street, Baltimore 1, Maryland. *President*, Miss Martha Johnson; *Second Vice-President*, Sister M. Florence; *Secretary*, Miss Irene J. Coleman; *Treasurer*, Miss Donnie M. Bay; *Directors*, Miss Elizabeth W. Sherwood; Miss Eleanor M. Harris; Miss Winnie A. Coxe; Miss Anna E. Holmes; Mrs. Lois W. DeBrule, and Miss Ethel Turner.

PHARMACY SECTION

L. M. KANTNER, Phar.D.

QUACKERY VS. SCIENTIFIC MEDICINE

Quackery still stalks in this enlightened age. Statements, which are unquestionably true such as "the American people receive the best medical treatment in the world" give members of the healing arts professions cause for pride. The American hospital is truly a wonderful institution. The facilities for the diagnosis of disease—and the wide array of medicinals that the physician has at his command to perform miraculous cures—give the public a deep sense of security so far as health protection is concerned. In spite of great scientific advances, attention is now and then focused upon the detection of unscrupulous operators who claim that their quack treatments produce definite cures.

Recently such an operator, who masqueraded under a self-conferred M.D. degree, was convicted in a western state for treating cancer, diabetes, arthritis or any other physical ailments of patients who applied. Federal and state food and drug officials are constantly on the lookout for such practitioners.

It is difficult to understand why people, regardless of their literacy, will gamble with their health, or even with their lives, and fail to recognize such charlatans. Unexcelled medical care is now available to people in all walks of life in this country.

Maryland is fortunate in that it does not have to contend with operators who dispense or manufacture medicinals as treatments for illnesses that actually require high-grade medical care. Under the Maryland law no drugs or medicines can be manufactured without a permit issued by the Board of Pharmacy. The Board requires that every applicant for such a permit submit the formula for the preparation, together with all printed matter to accompany it, if, or when it is sold. This method effectively prohibits fraudulent medicines from being manufactured or distributed.

"Medicine shows" that were popular not so many years ago are prohibited here. Recently a widely advertised medical preparation was being advertised by means of "caravans" employing popular "motion picture stars" as performers. These exhibitions or entertainments were presented in stadiums and other large places of public assembly and the purchase of a carton of the medicine was the only requirement for admission to the show. The sponsoring organization was served notice that Maryland did not permit such exhibitions, with the result that it by-passed this state.

Note to Doctors: The State Board of Pharmacy believes that it would be a splendid idea to adopt a policy of including on your prescriptons (except narcotic prescriptions) instruction to refill—as Refill 1–2–3–4, not to refill—as N.R., or to refill P.R.N.

APPROPRIATION REQUESTS OF INTEREST TO MEDICAL PROFESSION

Capitol Clinic, Vol. #3, No. 3

(Budget requests shown below are subject to increase or decrease by committees or on floor of House and Senate. They will provide funds for the period of July 1952 through June 1953, identified as "fiscal 1953." Figures shown below are in millions.)

	Provided by Congress For Fiscal 1952	*President's Requests For Fiscal 1953*
Civil Defense, medical stockpiling*	$ 50.0	$193.0
National Science Foundation	5.0	15.0
Public Health Service	334.5	292.4
Hill-Burton Hospital Construction	82.5	75.0
National Institutes of Health	16.8	15.5
Cancer Institute	20.6	16.7
Heart Institute	13.0	9.7
Children's Bureau, grants	31.5	30.0

* Civil Defense appropriations carry no new money for state-matching grants for medical stockpiling. The 1952 grants, according to the budget, are sufficient to assist all critical target areas to provide first-aid supplies and equipment for the first four hours after an attack. The $193 million listed above is for wholly federal procurement of medical supplies, based on CDA estimates that 2,700,000 casualties could be cared for with this amount of supplies.

No request was made at this time for funds for school and hospital construction in crowded defense areas, but $15 million may be asked later. Enough money was asked for Veterans Administration hospital construction to pay for construction already approved by Congress. Military Departments' budgets are not complete; Congress will be asked to consider them in supplemental appropriations bills. Health, welfare and education requests from all departments and agencies for fiscal 1953 are placed at $2,662 million, as against $2,680 million actually appropriated for fiscal 1952.

RURAL HEALTH TO BE NATIONAL CONFERENCE TOPIC

News Release from The American Medical Association

The problems of medical care in small communities were discussed at the seventh annual National Conference on Rural Health, in the Shirley-Savoy Hotel, Denver, February 29 and March 1.

The gathering, the most important of the year from a rural health standpoint, was sponsored by the Council on Rural Health of the American Medical Association, with the cooperation of farm organizations. It brought together about 700 medical, farm, civic and agricultural education leaders from all over the country. The theme was "Help Yourself to Health."